COMPLAINT/GRIEVANCE POLICY and FORM

Therapeutic Empowerment & Wellness (TEW) wants to provide you with the best services possible. To that end, we encourage you to communicate your thoughts about our programs and services. This form explains the procedures for communicating with our staff in the event that you have a complaint.

You will in no way be subject to reprisal, including denial or termination of services, loss of privileges, or loss of services as a result of filing a grievance.

You (your guardian, or other representative) are encouraged to try and communicate any concerns you may have directly with your provider. If you are unable (or unwilling) to do so, you may request a meeting with the individual's supervisor or another TEW representative, using the attached form.

Your complaint will be reviewed by Management within 2 business days of its receipt. At that time, TEW may ask for a meeting, additional information, or will issue a response.

A final response will be issued, in writing, within 5 days of meeting with the grievant, or receipt of the additional information requested.

If you are unsatisfied with the outcome of the grievance, you may file an appeal to Therapeutic Empowerment & Wellness CEO, who will respond to you within 5 days of receiving the appeal. They can be reached at 302.495.9773.

If you are not satisfied with their response, you may appeal to:

The Office of Health Care Quality
Maryland Department of Health
120 Samuel Morse Drive Columbia,
MD. 21046
1-877-402-8218
www.health.maryland.gov/ohcq

or

Office of Quality and Patient Safety
Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
1.800.994.6610
https://www.jointcommission.org/en-us/contact-us/report-a-patient-safety-event

Client Name: _____

Address:_____

Telephone: _____ E-mail:_____

Client/guardian or representative: _____

Address:_____

Telephone: _____ E-mail:_____

Please provide a detailed description of your complaint, and what resolution (if any) you are seeking:

_____

_____

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_____

_____

Signature of Client/Guardian/Representative: _____

Date: _____

For office use only. Attach copies of associated information and responses to this form and submit to Office Coordinator – info@therapeuticempowerwellness.com

Date received: _____

Date of response or request for additional information: _____

Date of receipt of additional information: _____

Date of Management response: _____

Notes: _____

To Complete this online: https://forms.gle/CrJYbdGpfcW14aVW7