Georgia Department of Community Health

Money Follows the Person
Participant Complaint Form

MFP Field Personnel: using the text boxes provided, 1) enter the participant's identifying information 2) summarize the issues and enter the action plan/process improvement/follow-up time frames, and 3) in the table provided, enter the vendor's information and identify the service that is the focus of the complaint using the drop down menu. Complete a separate form for each complaint and for each service.

1) Participant First Name:

Participant Last Name:

Participant Medicaid ID#:

Date of Birth (mm/dd/yyyy):

Address:

City: **Zip:** **County**:

Participant Phone Number:

Other Contact Name:

Other Contact Phone Number:

Discharge Date (mm/dd/yyyy):

Waiver Name: **Or** ☐ **Check for MFP CBAY**

MFP Field Personnel Name:

Phone:

Date of Complaint (mm/dd/yyyy):

Name of Person Completing Form:

Brief Summary of Complaint/Issues to Resolve:

Q1. Action Plan - What will be done to resolve the complaint and who will do what?

Q21. Process Improvement - What was instituted to evaluate the action plan and reduce risk to the participant?

Q3. Act/Monitor – What are the follow-up time frames for evaluating effectiveness of process?

Q4. Enter vendor name and contact information and use the drop down menu to select the service that is the focus of the complaint -

Vendor Name and Contact Infomation	MFP Transition Service
Vendor Name and Contact Infomation	**MFP CBAY Transition Service**

Note: Send the completed form to the DCH MFP Office via FTP or by fax to the MFP Project Director at 770-408-5883.