NEMCSA Region 9 Area Agency on Aging
MI Choice and Care Management Programs
Provider Feedback Report

CONFIDENTIAL

This form is to be used whenever a contracted provider identifies a problem.
Complete the appropriate sections and forward to Laurie Sauer for review.

Participant Name: _____ Participant ID #: _____

Program (if known): ☐ Waiver ☐ Care Mgmt. ☐ Caregiver Respite ☐ Other: _____

Agency making report: _____

Person Reporting Incident: _____ Date Reported: _____

Supports Coordinators: _____ Participant County: _____

Date	Type of Incident (complete all that apply)
	Work Order not faxed.
	Changes to Work Order not faxed.
	Stop Work Order not faxed.
	Initial Assessment pages not faxed or mailed.
	Reassessment pages not faxed or mailed.
	Return phone calls not prompt.
	Change in client status not reported (death, hospital admission, etc.)
	Client not available for service (no notification from family, client, or NEMCSA staff).
	Other (specify in comments)

Comments: _____

Provider Agency Supervisor Signature: _____ Date: _____

Office location: _____ Phone Number: _____

Submit form to: Laurie Sauer, Director
Region 9 Area Agency on Aging—NEMCSA
2569 US-23 South.
Alpena, MI 49707

NEMCSA Use Only

Supervisor Review Date: _____ **Acknowledgement letter sent:** _____

Follow-up done? Yes_____ No _____ Why not? _____

Issue resolved? Yes_____ No _____ Action taken: _____

_____

Supervisor Signature: _____