Client Service Delivery Feedback Form

Service delivery refers to the ways in which HIV providers such as doctors, case managers, receptionists, or employees provide you with services. Service delivery also includes the environment in which the agency operates, such as its physical location, waiting room, parking lot, and hours of operation.

The Form may be submitted anonymously by not fully filling out the optional sections but that will make it more difficult to thoroughly investigate and successfully resolve the service issue.

1. Information About Service Delivery Issues

Name of the agency or service provider:	Name of program/person at agency or service provider:	Dates service delivery issues occurred if known:

2. Details about Service Delivery Issues

Please provide a detailed description of the service delivery issue, including what happened, when and where it happened, how it happened, and why it happened. You may attach additional pages if there is not enough space on this form.

3. Suggestions for Improving Service Delivery

Please describe your suggestions for how to resolve this service delivery issue.

4. Your Information

Please check ☑ the item that best describes you. NOTE: A person living with HIV or AIDS (PLWHA) or service provider that is indirectly involved or may be someone that witnessed a service delivery issue but was not directly involved:

☐ Client Directly Involved ☐ Service Provider Directly Involved ☐ Other (specify): _____

☐ PWLHA Indirectly Involved ☐ Service Provider Indirectly Involved _____

5. Contact Information (Optional)

Last Name	First Name	Middle Initial
Agency/Title (if service provider)		
Address:	City/State:	ZIP Code:
E-mail Address:	Daytime Telephone Number:	Evening Telephone Number:
Best Way To Contact You:	Best Hours To Contact You:	
If we cannot reach you, is there someone else we can contact: Yes No Name: Phone Number:		
Do you need any special help in communicating with you about this issue? Yes No If yes, explain:		

6. Consent to Disclose Your Name (optional)

Please check ☑ one of the following:

☐ I DO consent to my name being disclosed to investigate this issue. We will share information about you in our investigation.

☐ I DO NOT consent to my name being disclosed. Not using your name may make it hard for use to investigate this issue.

7. Your Signature (optional)

Signature:	Date:

8. Form Submission Process

A. Form may be submitted directly to HAHSTA staff or by Mail to: **Attention:** Care Housing & Support Services Quality Management Specialist HIV/AIDS, Hepatitis, STD and Tuberculosis Administration 899 North Capital Street, N.E., 4th Floor Washington, DC 20002	Date Submitted:

B. Form may also be submitted directly to the appropriate Ryan White Committee Chair. The form will then be forwarded as appropriate to HAHSTA for a formal investigation as appropriate and final resolution.

C. Date form submitted: _____ to one of the following (Please check ☑ select one of the following:

☐ HAHSTA ☐ Consumer Access Chair ☐ Care Strategies, Coordination Standards Chair

☐ Other (please specify) _____.

ADMNISTRATIVE USE (for Internal Use ONLY)

A. Date Form Received:	Received By:
B. If form submitted to HAHSTA, indicate date:	

If form submitted to a committee, Please check ☑ to indicate committee:

☐ Consumer Access Committee ☐ Care Strategy, Coordination, & Standards Committee

☐ Planning Council ☐ Other:

C. Date Investigation Assigned:	To:
D. Date Investigation Completed:	By:
E. Date of Final Resolution:	By:
F. Date of Report to Provider:	By:
G. Date of Report to CSCS:	By:
H. Date of Report to Consumer Access:	By:

FINAL RESOLUTION

1. Action Taken:

2. Agency:

3. Staff Person: