St. Clair County Community Mental Health

Contract Provider Compliance Complaints – Quarterly Report

(SCCCMH Performance Indicator - CCC M-74)

Name of Reporting Entity: ____

Quarter Reported: ☐ **Quarter 1** (Oct-Dec) ☐ **Quarter 2** (Jan-March) ☐ **Quarter 3** (April-June) ☐ **Quarter 4** (July-Sept)

To comply with Service Contract requirements, the Contract Agency will submit a quarterly report listing all corporate compliance complaints or investigated over the quarter. If there were no complaints that quarter. If there were none, please indicate zero (0) and submit this form.

Number of Compliance Complaints Received in the Above-Noted Quarter: ___________________

Did the Contract Agency initiate any compliance investigations that were not in response to a report? ☐ No ☐ Yes #______

For each complaint, please provide the following information (please use additional form(s) if reporting more than three complaints)

Date of Complaint	**Referred to SCCCMH?** If No, please Findings & Outcome.	**Category of Complaint*** (Select all that apply)	**Findings**	**Outcome**
Example: 6/01/2024	☒ Yes ☐ No	☐ Fraud/Waste/Abuse ☒ HIPAA/Privacy ☐ Policy Violation ☐ Ethical Violation ☐ Other: _____________	☒ Substantiated ☐ Unsubstantiated ☐ Pending	☒ Training ☐ Policy Revision ☐ Process Revision ☐ Employee Discipline ☐ Other: _____________
	☐ Yes ☐ No	☐ Fraud/Waste/Abuse ☐ HIPAA/Privacy ☐ Policy Violation ☐ Ethical Violation ☐ Other: _____________	☐ Substantiated ☐ Unsubstantiated ☐ Pending	☐ Training ☐ Policy Revision ☐ Process Revision ☐ Employee Discipline ☐ Other: _____________
	☐ Yes ☐ No	☐ Fraud/Waste/Abuse ☐ HIPAA/Privacy ☐ Policy Violation ☐ Ethical Violation ☐ Other: _____________	☐ Substantiated ☐ Unsubstantiated ☐ Pending	☐ Training ☐ Policy Revision ☐ Process Revision ☐ Employee Discipline ☐ Other: _____________
	☐ Yes ☐ No	☐ Fraud/Waste/Abuse ☐ HIPAA/Privacy ☐ Policy Violation ☐ Ethical Violation ☐ Other: _____________	☐ Substantiated ☐ Unsubstantiated ☐ Pending	☐ Training ☐ Policy Revision ☐ Process Revision ☐ Employee Discipline ☐ Other: _____________

*The complaint may fall under more than one category, please select all that apply: Medicaid Fraud/Waste/Abuse (e.g., billing/coding errors, false claim, kickback, excluded employee, etc.), Policy Violations, Ethic Violations (e.g., conflict of interest), HIPAA/Privacy/Security Violation, and/or Other.

_________________________________ _________________________________ ____________

Signature & Job Title   Print Name   Date

If you have any compliance-related questions at any time, please contact:

Joy Vittone

SCCCMH Corporate Compliance Supervisor

jvittone@scccmh.org or (810)-966-3745

Admin Form: #01-0287
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