



CANCERcare®

Чтобы подать жалобу по поводу медицинского обслуживания в больнице в Департамент здравоохранения штата Нью-Йорк:

1. Go to:

<http://www.health.state.ny.us/nysdoh/healthinfo/complaintform.htm>. Then download, complete, and send the complaint form to the office in your area (see enclosed sample.)

OR

2. Call the office that serves your area to request a complaint form:

- A) New York Metropolitan – New York City Office Counties served: Bronx, Kings, New York, Queens, Richmond
(212) 417-5995**

- B) New York Metropolitan – New Rochelle Office Counties served: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
(914) 654-7011**

- C) New York Metropolitan – Central Islip
(631) 851-4300**

**NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL & PRIMARY CARE SERVICES**

NEW YORK STATE DEPARTMENT OF HEALTH COMPLAINT FORM

The New York State Department of Health is responsible for the ongoing surveillance of acute and primary care facilities in New York State to assure compliance with Article 28 of the Public Health Law. One of our primary program components in fulfilling this responsibility is the complaint review system. State Health Department regulations allow individuals to register complaints with the Department about the care and services provided by hospitals and diagnostic and treatment centers.

In order to make a formal complaint about a facility, please complete the information contained on the enclosed form and return it to:

Capital District Regional Office

Frear Building
One Fulton Street
Troy, NY 12180
Phone: (518) 408-5329

Central Regional Office

NYS Department of Health
217 South Salina Street
Syracuse, NY 13202
Phone: (315) 477-8561

Western Region – Buffalo

NYS Department of Health
584 Delaware Avenue
Buffalo, NY 14202-1295
Phone: (716) 847-4357

Western Region – Rochester

NYS Department of Health
Triangle Building
335 East Main St
Rochester, NY 14608
Phone: (585) 423-8053

New York Metropolitan - New Rochelle

NYS Department of Health
145 Huguenot Street, 6th floor
New Rochelle, NY 10801
Phone: (914) 654-7011

New York Metropolitan - Central Islip

NYS Department of Health
Metropolitan Area Regional Office
Court House Corporate Center
320 Carlton Avenue
Suite 5000 - 5th Floor
Central Islip, NY 11722
Phone: (631) 851-4300

New York Metropolitan - New York City

NYS Department of Health
90 Church Street, 15th Floor
New York, NY 10007
Phone: (212) 417-5995 or (212) 417-5990

Once received, trained personnel will review your complaint and a letter will be sent to you acknowledging receipt of your complaint. Please be advised that the Department will initiate a review of your concerns when we receive this **complaint form**.

**NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL & PRIMARY CARE SERVICES**

New York State Department of Health Complaint Form

Your complaint summary should provide a complete description of the issues you are requesting the Department to review. Where possible, please indicate the facility staff involved, the location of the facility and/or the patient's room number.

The Department will review those issues within the regulatory jurisdiction specified in applicable Federal regulations, State Rules and Regulations (NYCRR State Hospital Code) and applicable State Law, including complaints involving patient care, environmental issues or medical record access. The Hospital Complaint Program will generally process complaints filed within twelve (12) months of discharge or date of service.

Complaints beyond the Department's jurisdiction that will not be accepted for processing include:

- Financial complaints
- Complaints related to the attitudes of health care providers and ancillary staff at health care facilities
- Fees assessed by the facility, i.e. telephone access, television access, parking fees.
- Loss of personal property within a facility.
- HIPAA issues

NAME OF COMPLAINANT: _____
(FIRST) (MIDDLE INITIAL) (LAST)

ADDRESS: _____

TELEPHONE NUMBERS:

WORK: () _____ HOURS AVAILABLE AT THIS NUMBER: _____

HOME: () _____ HOURS AVAILABLE AT THIS NUMBER: _____

RELATIONSHIP TO PATIENT: _____

FACILITY: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____ PATIENT'S PHONE: _____

