

## Naval Hospital Oak Harbor IG Hotline Form

As an alternative to this form, you may contact our hotline answering machine at (360)257-9804, or to speak directly to local IG: (360)257-9718 or email: [hotline2@med.navy.mil](mailto:hotline2@med.navy.mil)

**Please complete the requested information to the best of your ability. Without complete and detailed information, we may have trouble investigating your complaint. You are not required to identify yourself.**

1. Do you wish to remain anonymous?  Yes  No

2. If you do not wish to remain anonymous, please provide the following contact information:

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Mailing Address (including city, state, zip code)

\_\_\_\_\_

\_\_\_\_\_

Home Telephone: (Area code & number) \_\_\_\_\_

Work Telephone (Area code & number) \_\_\_\_\_

Email address: \_\_\_\_\_

I DO/DO NOT consent to release my name to agencies outside the IG system under a "For Official Use Only" policy to facilitate resolution of my complaint. I understand that failure to authorize release may preclude timely resolution of my issues.

DO  DO NOT

3. If you are not remaining anonymous, would you like your case to be handled with confidentiality?

Yes  No

4. Are you willing to be interviewed?  Yes  No

5. Who is involved? Include everyone's first and last names, rank/pay grade, and duty station/place of employment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Subject(s): Who performed the wrongdoing?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witness(es): Who are the witnesses? \_\_\_\_\_

\_\_\_\_\_

6. What did the subject do or fail to do that was wrong?

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7. What rule, regulation or law do you think the subject(s) violated?

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8. When did the incident occur? Provide dates and times or "Early 2002," etc

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9. Where did the incident take place? What location, command etc.?

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10. Why do you think the incident took place?

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11. How have you tried to resolve the problem? Have you contacted your chain of command? Have you contacted your local Inspector General? Have you tried to resolve your complaint using an established process such as Bureau of Corrections of Naval Records, Informal Resolution System, EO/EEO or legal system?

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12. What do you want the IG to do?

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13. Additional information you wish to provide.

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**Submission Options:**

- Email

- Deliver to Command Evaluation, Building 993, room 274

- Mail to: COMMANDING OFFICER, NAVAL HOSPITAL OAK HARBOR, ATTN: COMMAND EVALUATION, 3475 N. SARATOGA ST., OAK HARBOR, 98278-8800

**THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (the Privacy Act of 1974).**  
**THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.**

**I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT.**  
**Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.**

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the ^Outcome and Assessment Information Set] (OASIS) assessment, it is protected under the federal Privacy Act of 1974 and the ^Home Health Agency Outcome and Assessment Information Set] (HHA OASIS) System of Records. You have the right to see, copy, review, and request correction of your information in the HHA OASIS System of Records.

**II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED**

The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70-9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes: A support litigation involving the Centers for Medicare & Medicaid Services; A support regulatory, reimbursement, and policy functions performed within the Centers for Medicare & Medicaid Services or by a contractor or consultant; A study the effectiveness and quality of care provided by those home health agencies; A survey and certification of Medicare and Medicaid home health agencies; A provide for development, validation, and refinement of a Medicare prospective payment system; A enable regulators to provide home health agencies with data for their internal quality improvement activities; A support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects; and A support constituent requests made to a Congressional representative.

**III. ROUTINE USES**

These ^routine uses] specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. the federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services;
2. contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity;
3. an agency of a State government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State;
4. another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services' health insurance operations (payment, treatment and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHAs;
6. an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
7. a congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

**IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION**

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.

**NOTE:** This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may **request** you or your representative to sign this statement to document that this statement was given to you. **Your signature is NOT required.** If you or your representative sign the statement.