QUESTIONS, CONCERNS, OR DISSATISFACTION WITH CARE OR SERVICE

Morongo Basin Community Health Center's goal is to provide the highest quality care and client satisfaction. Each health care provider and employee is responsible for creating an outstanding care experience for every client, every time. This includes responding to any concerns or dissatisfaction that you might have. Our highest priority is to resolve every concern or dissatisfaction wherever you receive care.

You have the right to appoint someone to file your grievance or represent you during the grievance process. In addition, grievances can be filed by parents, guardians, conservator, relative or other designee, if the patient is a minor or an adult who is incapacitated.

HOW TO FILE A GRIEVANCE

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction by:

1. Asking to speak to the manager of the department if you have a question, concern, or are dissatisfied regarding the care or service you received.
2. After speaking with the department manager, if questions, concern, or dissatisfaction continue, submit your grievance in one of the following manners:
    - Contact Angie Villaluz, Senior Manager of Quality at 760-365-9305, ext. 1503.
    - Complete this form and click the submit button (it will email to avillaluz@mbhdistrict.org).
    - Use your health plan's grievance process.

PATIENT INFORMATION

PATIENT NAME	BIRTH DATE
PATIENT ADDRESS STREET CITY ZIP CODE	
NAME OF PERSON MAKING THE COMPLAINT	DATE
DAYTIME TELEPHONE NUMBER	ALTERNATE TELEPHONE
EMAIL ADDRESS	
RELATIONSHIP OF PERSON FILING COMPLAINT: ❒Patient ❒Parent of patient ❒ Guardian of patient ❒Other:	

NATURE OF COMPLAINT

WHERE DID THE INCIDENT HAPPEN?

Rev 2/2023

WHEN DID THIS HAPPEN? (If unsure, give approximate dates)
WHO WAS INVOLVED?
PLEASE DESCRIBE WHAT HAPPENED. (Attach additional pages if necessary)

I agree and understand that by checking the signature box I am signing the Patient Grievance form, that all electronic signatures are the legal equivalent of my annual/handwritten signature, and I consent to be legally bound to this agreement. I further agree my signature on this document is as valid as if I signed the document in writing. This is to be used in conjunction with the use of electronic signatures on all forms regarding any and all future documentation with a signature requirement, should I elect to have signed electronically. Under penalty of perjury, I herewith affirm that my electronic signature, and all future electronic signatures, were signed by myself with full knowledge and consent and am legally bound to these terms and conditions.

AURTHORIZING SIGNATURE: *(name)* ____

By checking this box, I, hereby affix my signature to this document. ❐ Date: _______________

Relationship to the Patient: ❐Patient ❐ Legal Guardian Other: _________________________________

SUBMIT FORM

Rev 2/2023