**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 healthcare provider and employee are 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 another 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:

· 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

· After speaking with department manager, if questions, concern, or dissatisfaction continue, submit your grievance in one of the following manners:

- Contact Tricia Gehrlein, Chief Patient/Compliance Officer
- Complete and e-mail the attached form to tgehrlein@mbhdistrict.org
- Use your health plan's grievance process
- For more assistance, contact DMHC Health Center at 1-888-466-2219 or Ombudsman at 1-888-452-8609

**PATIENT INFORMATION**

| PATIENT NAME | BIRTH DATE |
|---|---|
| ADDRESS STREET CITY ZIP CODE | |
| DAYTIME TELEPHONE NUMBER | ALTERNATE TELEPHONE NUMBER |
| EMAIL ADDRESS | |
| PERSON MAKING THE COMPLAINT | DATE |
| SIGNATURE | RELATION |

**NATURE OF COMPLAINT**

| WHERE DID THE INCIDENT HAPPEN? |
|---|
| WHEN DID THIS HAPPEN? (IF UNSURE, GIVE APPROXIMATE DATE(S)) |
| WHO WAS INVOLVED? |

| |
|---|
| PLEASE DESCRIBE WHAT HAPPENED. (ATTACH ADDITIONAL PAGES, IF NECESSARY) |

PATIENT SIGNATURE DATE

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE
(IF THE PATIENT IS A MINOR OR INCOMPETENT)

**OFFICE USE ONLY**

| NAME OF PERSON RECEIVEING FORM | DATE RECEIVED |
|---|---|
| | |