



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
(IF THE PATIENT IS A MINOR OR INCOMPETENT)

DATE

OFFICE USE ONLY

NAME OF PERSON RECEIVING FORM

DATE RECEIVED