Grievance Form

Date: _____

Individual making grievance

Name: _____

Contact Number: _____

Date of Service: _____

Patient Information (if different)

Name: _____

DOB/MRN: _____

Contact Number: _____

Facility: ☐ Dilkon ☐ Leupp ☐ Winslow Department: _____

Check appropriate box below

☐ **Clinical Care** ☐ **Provider Behavior** ☐ **Customer Service** ☐ **Confidentiality/Privacy**

☐ **Security** ☐ **Services Provided** ☐ **Other:** _____

Please provide detailed information:

Submit to Patient.Advocate@wihcc.org or in person

Quality Management Department Use Only

Date Received: _____ Tracking #: _____

SUPERVISOR Notified on: _____ Response received: _____

PATIENT Reviewed/Resolution on: _____ ☐ In-Person ☐ Phone call ☐ Letter ☐ Meeting

Note: _____

DAYS TO RESOLVE: