

**Forest County Potawatomi Health and Wellness Center**  
**PATIENT COMPLAINT OR GRIEVANCE REPORT**

Patient Report # \_\_\_\_\_ (to be completed by Compliance Department)

**TYPE OF CONCERN (Please check one):**

**Patient Complaint** \_\_\_\_\_

**Patient Grievance** \_\_\_\_\_

**A Patient Complaint** is a concern about the services you received (or did not receive) – please attempt to resolve the concern by addressing it directly with the staff involved or department supervisor. We will be happy to assist you in this process. Please call Compliance at 478-4356.

**A Patient Grievance** is: a concern about the services you received (or did not receive) at the Forest County Potawatomi Health and Wellness Center. **You have attempted to resolve this concern with the staff involved or department supervisor and are not satisfied with the outcome.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Date and Time of Incident:** \_\_\_\_\_

**Staff Member(s)/Department(s) Involved in incident:**  
\_\_\_\_\_

**Describe the complaint or grievance:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check one of the following:**

I have attempted to address my concern and am not satisfied with the outcome. Please identify how you attempted to resolve your concerns, with whom and the reason you are not satisfied:  
\_\_\_\_\_  
\_\_\_\_\_

I have **not** attempted to resolve my concern because:  
\_\_\_\_\_  
\_\_\_\_\_

How do you suggest the complaint or grievance be resolved?

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What do you want to happen as a result of this complaint? (Suggested action(s) to be taken):

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\_\_\_\_\_  
Signature of Patient (Individual Filing Grievance) Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of legal guardian or patient representative Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

### **FOREST COUNTY POTAWATOMI HEALTH AND WELLNESS CENTER PATIENT'S RIGHT TO FILE COMPLAINTS AND GRIEVANCES**

The Forest County Potawatomi Health and Wellness Center ("FCPHWC") takes patient complaints seriously. We review and respond to them thoughtfully and in a timely manner. The forest County Potawatomi Health and Wellness Center uses information obtained from patient complaints to improve and enhance the quality of patient care.

#### **Patient Complaints and Grievance Policy**

- Patients are encouraged to voice their concerns and, recommendations for change in or enhancement of FCPHWC's policy or service.
- FCPHWC has a mechanism for receiving, responding to patients' and families' complaints concerning the quality of care. This mechanism is our Performance Improvement System.
- Patients and families are informed of their right to present complaints and of how to do so through the Patient Bill of Rights posted in each department throughout the FCPHWC. FCPHWC analyzes the complaint, and, when indicated, takes appropriate corrective action.
- Where appropriate, FCPHWC will contact patients and/or families with information about how the complaint was resolved.
- Filing a complaint will not in any way compromise the quality of care given to a patient or impede access to future care.

#### **If You Have a Concern About Your Care or Wish to File a Complaint:**

- Please immediately tell any clinic employee or department supervisor about your concern. This provides us with the best opportunity to resolve the problem right away.
- If you are not satisfied with the way a concern is handled or would like to register a formal complaint, you may request to see or contact the Compliance Coordinator/Privacy Officer (2<sup>nd</sup> floor Administration) at (715) 478-4356. Billing complaints should first be directed to the Collections Clerk at (715) 478-4312.
- Your concerns will be investigated in a timely manner. Once a determination is made you will be contacted either verbally or by letter. If you are not satisfied with this decision, you may appeal. We request that such an appeal be made within 10 days. To Appeal, contact the Health Administrator at (715) 478-4358.
- If you choose to appeal, a final review of your concerns will be made by the Health Administrator and the Tribal Administrator. A member of the Health Administration will inform you of the final decision regarding the resolution of your complaint either verbally or in writing within 15 days.

**MISSION STATEMENT:** To promote quality health care in a professional and traditional way for Native Americans, their families, and the surrounding community; in a trusting, respectful, and confidential manner for the wellness and future of the community.