HO-CHUNK NATION
DEPARTMENT OF HEALTH

PATIENT COMPLAINT FORM

If you have a concern about the services you received through the Ho-Chunk Nation Health Care facilities, please complete this form and return to Quality Improvement Director.

Patient Name: _____ Date: _____

Address: _____ Contract Number: _____

Date and Time of Incident: _____ Staff Involved: _____

Describe Incident/Complaint: (use back or addition sheets if needed).

How do you feel the problem can be resolved?

What do you want to happen as a result of this complaint?

I understand that I may revoke this complaint in writing at any time, except to the extent that action has been taken against this complaint.

_____ _____
Signature of Client Date

_____ _____
Representative Receiving Date

N6520 Lumberjack Guy Road, Black River Falls, WI 54615
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