HO-CHUNK NATION

DEPARTMENT OF HEALTH

Client Feedback Form

Did you receive exceptional care? Do you have other questions, comments, or feedback for improvement? Let us know! *Please write-in or check-mark (✔) the response which best reflects your answer and return this form to Quality Improvement Division.* ***If your feedback is related to a complaint, please fill out your contact information and other details on the backside of this page.***

Date of service *(that feedback is related to)*_____

1.At which site is your feedback related to?

❍ Black River Falls ❍ Baraboo ❍La Crosse ❍Tomah ❍Wittenberg ❍Nekoosa ❍Madison

2.What kind of feedback? (Check all that apply)

❍Question ❍Comment ❍Feedback for improvement *(including complaints)*

3.Which area of service did you use? (Check all that apply)

❍Pharmacy ❍Optical ❍Dental ❍Lab/radiology

❍Clinic/medical ❍Clinic Registration ❍Benefits/billing ❍Behavioral Health

❍Environmental Health ❍Community Health ❍Not listed *(please write in)*:_____

4.Reason for feedback? (Check all that apply)

❍Scheduling/registration ❍Clinic conditions (cleanliness, temperature, etc.) ❍Customer service

❍Safety ❍Not listed *(please write in)*:_____

5.Please share a little more detail about your experience:

_____

_____

_____

_____

_____

Wa'iniginapsana! Thank you! We value your time and your feedback.

For complaints only, please turn over this page and fill out the additional information. **Turn Over**

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If you have a concern about your experience or the services you received through the Ho-Chunk Nation Health Care facilities, please complete this section. All complaints are given serious attention and are kept confidential.

Complaint Section

6.How could this situation have been prevented? (Check all that apply)

❍Communication ❍Organization ❍Preparedness

❍Training ❍Attention to detail ❍Sympathy/compassion

❍Knowledge of my culture ❍Professionalism/respect ❍Facility design/environment

❍Not listed (please write in):_____

7.How can this situation be resolved? (Check all that apply)

❍Training/knowledge ❍Counseling ❍Updating policies or procedures

❍Not listed *(please write in)*:_____

8.Is there anything else you would like to share with us about your experience?

_____

_____

_____

_____

Client Contact Information

Name:_____ Address:_____

Phone number:_____ Email:_____

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

_____ _____

Signature of Client *Date*

_____ _____

Representative Receiving *Date*

Mail your form to: **QI Director Daniel Libke,** Ho-Chunk Health Care Center, N6520 Lumber Jack Guy Rd , Black River Falls, WI 54615 - or - email: **Daniel.Libke@ho-chunk.com**