



Patient Grievance Form

Hill Health Center is responsible for providing and maintaining good quality medical care and a responsive system for delivering medical care and service to all patients. Since we at HHC make every reasonable effort to satisfy patients within the framework of providing and delivering good medical care and service, we realize that sometimes problems occur. If you believe our personnel have not been reasonable in resolving your problem, you may file a grievance with HHC's Patient Advocate, who will investigate your grievance in accordance with the Patient Complaint and Grievance Procedure. You must sign and date the form. The HHC Patient Advocate is:

Gladys Martinez, Patient Advocate
428 Columbus Avenue, New Haven, CT 06519
Phone: 203.503.3211; Fax: 203.503.3223
Email: gmartinez@hillhealthcenter.com

Patient Name _____ HHC Number _____

Patient Guardian or Representative signing the form _____

Address _____ Telephone _____

Date of incident _____ Time _____ Location _____

Name of HHC employee involved _____

If name of the employee is not known, describe the person

Please state your grievance (add additional sheet if necessary):

Signature: _____ Date: _____

Please give the completed form to the Patient Advocate or you can fax or email the form to the Patient Advocate. HHC will investigate your grievance and it will be evaluated against established HHC policies and practices and a determination will be made. You will be notified of this determination.

FOR HHC USE ONLY:

Date Received by Patient Advocate: _____ Case ID#: _____

Date HHC Employee Notified: _____

Date Status Letter to Patient: _____