



CLIENT & FAMILY CONCERNS / GRIEVANCES FORM

Our Hoffmann Hospice staff strives to ensure quality hospice care services that are consistent with our philosophy.

As stated in your Patient Rights and Responsibilities you have the right to receive professional quality hospice services, and to be treated with dignity and respect. You also have the right to voice concerns, grievances or complaints about your service without being subject to reprisal. The complaint will be investigated and Hoffmann Hospice will document the existence and resolution of the complaint.

If you are unhappy with our service, we would like you to inform us. You may either complete this form or call us at the number listed below. We will contact you within 48 hours of receipt of your concern.

Name: Beth Hoffmann
Title: Administrator
Phone: 661-410-1010
Or
Toll Free: 888-833-3900

Mail form to: Hoffmann Hospice
4325 Buena Vista Rd, Bldg A
Bakersfield, CA 93311

Thank you in advance for bringing your concern to our attention as it will assist us in our continuing effort to improve the quality of our hospice service.

Your Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Description of the problem or concern (include any pertinent dates, times and names): \_\_\_\_\_

Multiple horizontal lines for describing the problem or concern.

Form completed by (signature): \_\_\_\_\_

Date