monogram health

Discrimination Grievance Form

YOUR FIRST NAME	YOUR MIDDLE NAME	YOUR LAST NAME

YOUR STREET ADDRESS

CITY	STATE	ZIP

YOUR PHONE (Please include area code)

If you are *not* a Monogram Health patient, but are filing this complaint *on behalf of* a Monogram Health patient, please provide the following information:

PATIENT'S FIRST NAME	PATIENT'S MIDDLE NAME	PATIENT'S LAST NAME

PATIENT'S STREET ADDRESS

CITY	STATE	ZIP

PATIENT'S PHONE (Please include area code)

If filing on behalf of a Monogram Health patient, what is your relationship to the patient?

☐Parent/Legal Guardian ☐Personal Representative ☐Attorney ☐Family/Friend ☐ Other/Advocate

Monogram Health will generally need the signed consent of the patient to proceed with investigating a complaint filed by someone other than the patient. If you have any documentation showing that you are legally authorized to act on behalf of the patient, please include a copy of the supporting documentation when submitting this form.

I believe that I (the patient) have been discriminated against based on:

☐Race ☐Color ☐National Origin ☐Age ☐Disability ☐Sex ☐Other _____

When do you believe the discrimination occurred? (A discrimination complaint must be filed within 60 days from the date the alleged discrimination occurred, unless the timeframe for filing is extended by Monogram Health.)

List date(s) alleged discrimination occurred (mm/dd/yyyy)

Describe the acts of discrimination that you believe have occurred and explain why you believe the acts were discriminatory. If you checked more than one basis of discrimination above, please provide details for each basis. (Attach additional pages if needed.)

What resolution are you seeking (for example: access to Monogram Health services, an interpreter for future appointments, training of Monogram Health staff, etc.)?

Please sign and date this complaint.

SIGNATURE	**TODAY'S DATE** (mm/dd/yyyy)

Submit your written complaint, along with any pertinent documents, to Monogram Health:

Mail:

Monogram Health, Inc.

Attn: Grievance Department

5410 Maryland Way, Suite 301

Brentwood, TN 37207

Fax:

1-920-882-1182

Email:

AGC@monogramhealth.com