Please fill and email to: gbates@spvmhc.org

Complaint/Grievance Form

Date: _____

Clinic/Program: _____

Name of Person Filing Complaint/Grievance: _____

Relationship to Client: _____

Address and Phone Number of Person Completing Form: _____

_____

Name of Client: _____

Address and Phone Number of Client:_____

_____

Please Check:
☐*Complaint* ☐*Grievance* (A grievance is an issue that pertains to one of the Client Rights as stipulated by the Ohio Department of Mental Health. Complaints are concerns that are not related to Client Rights.)

Name of staff person(s) involved: _____

_____

What is Your Concern?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Client Right Category (Check All That Apply)

☐Right to Dignity & Respect
☐Right to Informed Choice & Treatment
☐Right to Freedom
☐Right to Personal Liberties
☐Right to Freely Exercise All Rights
☐Complaint Involves a Non-Rights Related Matter

Explain How Right(s) Were Violated:

_____
_____
_____
_____
_____
_____

How would you like to see this grievance resolved?

_____
_____
_____
_____
_____

Final Resolution/Disposition (Agency Staff to Complete):

_____
_____
_____
_____
_____

Date Closed (Agency Staff to Complete): _____

Dates/Times/Names of Contacts (Agency Staff to Complete)

1. _____ 2. _____ 3. _____

4._____ 5._____ 6. _____

Staff Who Investigated Complaint: _____
_____