

Please fill and email to: [bmahaffey@spvmhc.org](mailto:bmahaffey@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:**

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**How would you like to see this grievance resolved?**

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**Final Resolution/Disposition (Agency Staff to Complete):**

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**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:** \_\_\_\_\_

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