Grievance Report Form

It is the policy of Signature Health that clients can file grievances at any time without concern for reprisal.

Client name: _______________________________ Date of Report: ________________

Name of Client’s Provider: __________________ Program Name: ________________

Case Number (if applicable): ________________ Date & Time of incident: ______

Type of Grievance:

_____ Confidentiality _____ Behavior _____ Information

_____ Client Records _____ Denial of Service _____ Medication

_____ Consultation _____ Discrimination _____ Restraint

_____ Termination _____ Observation _____ Financial

_____ Participation _____ Treatment _____ Services

Other (please list):

_____________________________________________________________________________________
_____________________________________________________________________________________

Describe Situation:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Persons Involved:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Client Signature: _______________________________ Date: ________________

Client Rights Officer Signature: _______________________________ Date: ________________

Date Initiated: ________________ Date Resolved: ________________