



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