CLIENT GRIEVANCE REPORT FORM

SECTION I – Client, Parent or Companion to complete  (All items in Section I must be completed for response)

✓ Client Name (print full name): ____________________________________ Program: ____________________

☐ Active Client ☐ Discharged Client

✓ If not client, check the appropriate box below and print contact information:

☐ Parent of Adolescent Client ☐ Companion of Deaf/Hard of Hearing Client

Full Name, Address and Phone Number: ____________________________________________

✓ Nature of concern - Check only one: (Forms will be returned for clarification if more than one is checked. Use a separate form if multiple issues.)

<table>
<thead>
<tr>
<th>Respect, Dignity &amp; Caring</th>
<th>Quality of Care</th>
<th>Communication</th>
</tr>
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<tbody>
<tr>
<td>Poor Staff Attitude</td>
<td>Competence</td>
<td>Lack of Communication</td>
</tr>
<tr>
<td>Rude/Disrespectful</td>
<td>Professionalism</td>
<td>Miscommunication</td>
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<tr>
<td>Treated unfairly</td>
<td>Ethics</td>
<td>Trust/Follow Through</td>
</tr>
<tr>
<td>Abuse of Authority</td>
<td>Boundaries</td>
<td>Dishonesty</td>
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<tr>
<td>Physical Contact</td>
<td>Timing and Access</td>
<td>Lack of Follow-Through</td>
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<tr>
<td>Intimidation/Coercion</td>
<td>Assessment</td>
<td>Environmental of Care</td>
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<tr>
<td>Discrimination/Prejudice</td>
<td>Admission</td>
<td>Cleanliness</td>
</tr>
<tr>
<td>Other Clients’ Behavior</td>
<td>Medical</td>
<td>Temperature</td>
</tr>
</tbody>
</table>

Client Rights

Access to Records

Input into Treatment

Program Rules

Finance and Billing

Family Involvement

Writ of Habeas Corpus

To File a Grievance

Confidentiality

Unauthorized Disclosure

Discharge

| Confidentiality                      | | |
|--------------------------------------| | |
| Unauthorized Disclosure              | Discharge               | |
|                                      | Wrongful Discharge       | |

✓ Provide a detailed description of the concern – include facts dates, places, persons involved, etc.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Have you attempted to resolve this concern with a counselor or other staff:  ☐ Yes  ☐ No
✓ Name of individual and outcome of discussion: __________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
✓ What do you think would solve this problem? (Required)
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
Client/Parent/Companion Signature: __________________________________________ Date: ________
   When complete, turn into any staff. They will sign and date and provide you with a copy.
Staff (PRINT NAME) : __________________________________________ Date: ________

If completing on-line, please return form to:
PEMHS
ATTN: Quality Management
11254 58th ST N.
Pinellas Park, FL 33782