DEPARTMENT OF PSYCHIATRY CLIENT GRIEVANCE

CLIENT _____ CLIENT RIGHTS OFFICER _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

This form constitutes the written record for filing a grievance and for monitoring the grievance procedure. Copies of this form and all attachments may be provided to the client, designees of the client, St. Vincent Charity Hospital and Health Center Psychiatric emergency Services, Department of Legal Affairs or designees, and the Cuyahoga County Community Mental Health Board. This procedure is in accordance with regulations of the State of Ohio department Mental Health (51222-1-02).

Name of Person Filing Grievance: _____

Date Grievance Filed: _____ (grievance to be resolved within 20 working days of filing date)

Date of Incident: _____

Describe incident (attach additional pages if necessary):

Grievance resolved through discussion with Client Rights Officer: Yes ☐ No ☐ Date _____

Grievance resolved through hearing with SVCH & HC Dept. of Legal Affairs: Yes ☐ No ☐ Date _____

Grievance resolved through hearing with Director of Psychiatry/Chemical Dependence: Yes ☐ No ☐ Date _____

Grievance resolved through hearing with (specify): _____ Yes ☐ No ☐ Date _____

Signatures After Resolution:

_____ Client (or designee)

_____ Client Rights Officer (or designee)

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A Ministry of the Sisters of Charity Health System