

# Grievance Form

Name of Agency Organization/Facility/Clinic/Service Provider \_\_\_\_\_

Name of Person (plaintiff): \_\_\_\_\_

Date of Submission: \_\_\_\_\_

Reason(s) for grievance (s): \_\_\_\_\_

Right(s) violated: \_\_\_\_\_

Evidence provided: \_\_\_\_\_

Relief Resolution Sought: \_\_\_\_\_

\_\_\_\_\_  
Signature (Plaintiff or person complaining on Patient's behalf (Advocate)

\_\_\_\_\_  
Date

**Note:** Grievances are not required to be written. Grievances can be submitted to the Client Rights Specialist orally. If grievances are communicated orally, the grievant should inform the Client Rights Specialist that it is the grievant's intent to file orally.