



## Grievance/Complaint Form for Persons Served

Filing a grievance/complaint will not affect your treatment.

**When you complete the form, place it in the suggestions box.**

Person(s) Completing Form: \_\_\_\_\_  
(Self – Person served, Program Director, Supervisor, Therapist, Milieu)

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ Program: \_\_\_\_\_

Grievance/Complaint: (Include basis of complaint: race, color, or national origin. What happened, who was involved, where did this happen? Was an attempt made by staff to resolve the grievance/complaint?) (Continue on the back or use an additional page if necessary.) **Do not abbreviate or use acronyms. Handwriting must be legible.**

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Would you like a representative of the Quality Management Division to contact you?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide your telephone number. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If you do not have a telephone number, you may contact the Quality Management Division at (305) 398-6197.

Person Served Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### THIS SECTION TO BE COMPLETED BY QUALITY MANAGEMENT ONLY

Date Complaint Received: \_\_\_\_\_ Time Complaint Received: \_\_\_\_\_

Date Complainant Contacted: \_\_\_\_\_ Time Complainant Contacted: \_\_\_\_\_

Grievance/Complaint Resolved by Program Director/ Supervisor Yes \_\_\_\_\_ or No \_\_\_\_\_

Grievance/Complaint Resolved by \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Attach Resolution Form, use back of form if necessary)