RIVER ROOT COUNSELING
CLIENT COMPLAINT FORM

Facility / Agency /
Provider / Program:

Complaint filed by:
(Client /Family Member)

I can be reached at:
Address **Phone #**

COMPLAINT INFORMATION

Date: **Time:** **Location:**

Name or Descriptions of Individuals involved in the incident/situation of complaint:

Name(s) of witnesses of incident / situation:

Brief Narrative of the incident / complaint: (continue on reverse side if you need additional space)

I understand that further interviews with the Owner or his/her designee, other staff, or a review of my clinical record may be necessary to fully investigate this matter. I therefore give the Executive Director or his/her designee authority to conduct the necessary investigation. I also understand that I have the right to have someone assist me with the complaint. If I am not satisfied with the results of the investigation, I have the right to file a complaint with the state of Ohio Department of Healthcare Services.

Name of Complainant:_____ **Date: _____**

Name of Staff Receiving/handling complaint: _____Date: _____
Date: **Time:** **Location:**
Follow Up/Resolution:

(continue on reverse side if you need additional space)

Client received a copy of resolution: ☐ in person ☐ by mail
☐ Client would like further investigation
☐ Client would like to request a meeting with Client Rights Representative

Client:
☐ My signature indicates that my complaint has been resolved to my satisfaction.

Signature of complainant: **Date:**

Staff:
☐ **My signature indicates that client gave a verbal indication over the phone that this complaint has been resolved to their satisfaction.**

Signature of staff: **Date:** **Time:**

Recommendations to Administration to prevent similar complaints:

Client Rights Committee Follow-up: