STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A Healthcare Service Agency

CLIENT GRIEVANCE FORM

Submitted to Client Rights Officer or designee

(2 pages)

DMHAS Facility/Program or Covered Service Provider: _____

Grievance submitted by: _____
(Client or person legally authorized to act on the client's behalf)

Contact information: _____
(Street Address)

_____ **Phone Number:** _____
(City, State and Zip Code)

Are you asking for help from an advocate? ☐ **Yes** ☐ **No**

Describe your complaint:

- ***Include: What Happened, When and Where Did It Happen; Who Was Involved and Names of Any Witnesses.***

(Continue on other side – Attach additional pages if necessary)

DMHAS CLIENT GRIEVANCE FORM

(Continued from other side)

Remedy/remedies you are seeking:

(Attach additional pages if necessary)

I authorize the Client Rights Officer (CRO) or designee to take any action likely to assist in resolving this grievance including: interviewing me (with my advocate present) and other involved parties; reviewing pertinent documents and proposing an informal resolution that may include offering options such as mediation between all parties.

(Signature of the client or person legally authorized to act on the client's behalf) **(Date)**

(Signature of Client Rights Officer or designee who received this grievance) **(Date received)**

FOR MORE INFORMATION ON THE DMHAS GRIEVANCE PROCEDURE CONTACT:

Client Rights and Grievance Specialist, Department of Mental Health and Addiction Services,
410 Capitol Avenue 4th Floor PO Box. 341431 Hartford, CT 06134 1-800-446-7348 (#6933) or 860-418-6933

Confidentiality: This form is intended only for the individual(s) to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law.