



This form should be used when you feel you were not treated with courtesy, consideration and/or respect by an employee of Comprehensive Mental Health Services, Inc.

NO RETALIATION WILL BE TAKEN AGAINST YOU FOR FILING THIS COMPLAINT OR PROCEEDING WITH THE GRIEVANCE PROCEDURE.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

The questions below are to be answered by the person making the complaint or by a person acting with the knowledge and consent of the person making the complaint.

1. Please identify the primary reason for this complaint.

Staff/provider       Policy/procedure

2. What was the date of the incident? \_\_\_\_\_ 3. Who is the complaint against? \_\_\_\_\_

4. Please explain the incident or the nature of the issue/concern that prompted this grievance.

5. What do you want Comprehensive Mental Health Services, Inc. to do in response to your grievance?

\_\_\_\_\_  
Signature of Individual Filing Grievance

\_\_\_\_\_  
Date Form Completed

***If this form is being completed by another individual on behalf of the client:***

\_\_\_\_\_  
Name & Signature of Individual Completing

\_\_\_\_\_  
Date Form Completed

*Please send completed form to:  
Quality Management; Consumer Advocacy  
Comprehensive Mental Health Services  
PO Box 260  
Independence, MO 64051*