FORMAL COMPLAINT & GRIEVANCE FORM

Clients may use this form to submit a formal complaint or grievance regarding any aspect of their care, treatment experience, administrative interaction, or environment of service.

Below is a narrative description of the fields included on the form:

- **Client Name**
- **Date of Birth**
- **Phone Number**
- **Email Address**
- **Date of Incident or Concern**
- **Name(s) of Staff Involved (if applicable)**
- **Description of Concern or Complaint**
  - Space for a detailed written explanation
- **Actions Already Taken (if any)**
- **Requested Resolution or Outcome**
- **Client Signature and Date**
- **Staff Receiving the Complaint (for internal use)**
- **Investigation Notes (internal)**
- **Resolution and Action Steps (internal)**
- **Follow-Up Communication (internal)**

Clients may submit completed forms:

- In person
- By email - contact@pilcounseling.com
- By postal mail - 522 S. Independence Blvds. Ste. 102D, Virginia Beach, VA 23452
- Through secure client portal messaging

All complaints are handled in accordance with PIL's grievance policy outlined earlier in this handbook.

Formal Complaint / Grievance Form

Complainant Information

Name: _____

Role (Patient / Staff / Family / Other): _____

Phone: _____

Email: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Mail

Incident / Complaint Details

Date of Incident: _____

Time of Incident: _____

Location: _____

Individuals Involved (if known): _____

Type of Complaint (check all that apply):

☐ Rights & Respect

☐ Safety Concern

☐ Access / Timeliness of Services

☐ Staff Conduct

☐ Environment of Care

☐ Clinical / Medication Issue

☐ Privacy / Confidentiality

☐ Discrimination

☐ Other: _____

Description of Complaint

(Please describe the incident. Attach additional pages if needed.)

_____

_____

_____

Desired Resolution

_____

_____

Complainant Signature

I affirm that this information is accurate to the best of my knowledge.

Signature: _____

Date: _____

For Office Use Only

Received By

Staff Member Receiving Complaint: _____

Date Received: _____

Complaint ID: _____

CARF Standard Category

☐ Person-Centered Focus

☐ Health & Safety

- [ ] Rights & Ethics
- [ ] Leadership & Governance
- [ ] Performance Improvement
- [ ] Clinical Care

Risk Level

- [ ] Low
- [ ] Medium
- [ ] High

Investigation Summary / Findings

_____

_____

Corrective Action Plan

_____

_____

Responsible Staff/Department: _____

Target Completion Date: _____

Outcome / Follow-Up

- [ ] Resolved
- [ ] Partially Resolved
- [ ] Unresolved (explain): _____

Follow-up Date: _____

Reviewer Signature: _____