



Patient Grievance Form

I understand that I have three (3) working days to respond to any proposed resolutions. If I do not respond within the three (3) working days, the grievance is considered resolved. I understand this form can be turned in to any Cove employee.

SECTION 1

Patient Name (Print) Date Cove Program

Contact Telephone Number Patient ID No

Check Appropriate Box: **Enrolled Patient** **Discharged Patient**

Nature of concern: _____

Have you attempted to resolve this concern with the individual involved: **Yes** **No**

Outcome of discussion with individual/counselor: _____

What do you think would solve this problem? _____

Patient Signature: _____ **Date:** _____
Signature of Receiving Staff: _____ **Date:** _____

Employee: Submit this form IMMEDIATELY (within 24 hours) to the QI Dept.

SECTION 2

Supervisor/Mgt/Designee: _____ Date Received: _____
Date reviewed with patient: _____

Proposed Resolution: _____

I am satisfied with the proposed resolution
I am not satisfied with the proposed resolution

If not satisfied, please explain what solution you propose: _____

If I do not respond to the proposed resolution within three (3) working days, the grievance is considered resolved.

Patient Signature: _____ **Date:** _____

Supervisor/Manager: Return this form IMMEDIATELY (within 24 hours) to the QI Dept.