SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

GRIEVANCE - CONCERNS FORM

Use this form to let us know if you have any of the following:

☐ **COMPLIMENT** — If you have something nice to say about a service, a program, staff and/or a specific employee.

☐ **SUGGESTION** —If you have any idea as to how we may better serve you or improve our services.

☐ **GRIEVANCE** — If you have a concern regarding your safety, service, a program, an employee, or your rights as defined in Nevada Law.

With regard to services received at:

☐ Rawson Neal Psychiatric Hospital, Unit _____
☐ West Charleston Inpatient Services, Unit _____
☐ Community Services
☐ East Las Vegas Clinic
☐ Henderson Clinic
☐ West Charleston Clinic
☐ Laughlin Clinic
☐ Mesquite Clinic

1) Please describe your compliment or suggestion for improved services in the space below.

2) Before completing a written grievance, please try to resolve the matter with an employee or your treatment team. An employee or your team will meet with you to discuss your concerns in an attempt to resolve it. We appreciate your cooperation to find a resolution.

3) If you wish to submit a formal grievance, please describe your grievance below. Use the back of the form if you need more space. You may also attach additional pages.

Date:

4) You may submit this form anonymously and do not have to complete the information below. You may drop this in one of the Community Consumer Rights Boxes. If you are currently in an inpatient program, you may ask an employee for an envelope for your form or you may put it in one of the inpatient Consumer Rights Boxes, which are located in the activities areas.

5) If you **do not** wish to remain anonymous, **please print your name below:**

6) If you wish to be notified of the resolution, please provide a telephone number below.

Current Telephone:	Home Telephone:	Other Telephone:

Return this form to us in any one of the following ways:

1. Mail the form to: **Recovery Services Coordinator**, 6161 West Charleston Blvd. Bldg.1, Las Vegas, Nevada 89146
2. FAX the form to **Office of Recovery Services Coordinator** at 702-486-7703
3. Give the form to any SNAMHS employee or receptionist.

This section to be completed by SNAMHS personnel Activities and Closure:			
Date Received:		Received By:	
Date Reviewed by R.S.C		Reviewed By:	
Level Assigned:		Action Taken:	

Please describe all actions taken to resolve. Check all boxes that apply. Attach additional documents if necessary. Return to the Recovery Services Coordinator (RSC). **Level I grievance** -Staff must provide a written response to the grievant.

☐ Reviewed with consumer to clarify	☐ Met with Treatment Team	☐ Met with involved employee(s)
☐ Reviewed with consumer to identify activities taken to resolve	☐ Provided staff training	☐ Provided employee counseling
☐ Provided consumer education	☐ Followed Personnel Policy	☐ Re-engineered a process
☐ Copy of form provided to consumer	☐ Revised procedure	Internal investigatory review conducted
☐ Other (Describe below)	☐ Reviewed trend	

☐ Unable to review with consumer (If checked, please identify reason below.)

☐ Unable to resolve at this time due to the consumer's clinical condition and request an extension (If this is checked, please identify the reason below. Include the date projected to complete and notify the R.S.A. and consumer's representative (If applicable) in writing.

Comments:

Grievance Received a Response From (print name):	Signature and Date:	E-mail:

Individuals coordinating the review and follow up of this compliment or concern are to return this form to the Office of the Recovery Services Coordinator

As applicable, complete the section below if the resolution was reviewed with the grievant.

Date:	Print name:	Signature:	E-mail:

☐ I am satisfied. ☐ I am not satisfied and wish to appeal.