PERMIACARE

CLIENT COMPLAINT FORM

Person Registering the Complaint: ☐ Self ☐ Parent/LAR/Guardian ☐ Other **Date:** _____

First Name	Last Name
Address	City
Daytime Phone	Evening Phone
Email Address	
Program	

Client Information (if other than the person registering the complaint)

First Name	Last Name
Address	City
Daytime Phone	Evening Phone
Email Address	
Program	

Provide Details of your concern as appropriate/applicable

Date of Incident	Time of Incident
Name(s) of Staff Member Involved	
What is your complaint/concern:	
Describe any efforts you made to resolve this matter:	
Please describe the result or outcome that you seek:	
Do you consider this matter urgent? ☐ **Yes** ☐ **No**	**Reasoning:**

Please forward this completed form to:
Amber Johnson
Client Rights Advocate
401 E. Illinois Ave, Suite 403
Midland, TX 79701
Email: amberjohnson@permiacare.org
Phone: 432-570-3333

ADMINISTRATION USE ONLY							
RECEIVED DATE			RESPONSE DATE				
PROGRAM	___ Mental Health	___ SUD Program	___ IDD	___ ECI	___ Other		
COMPLAINT TYPE	_ Non-Complaint	_ Unprofessional Behavior	_ Service Delivery/Clinical Practice	_ Access to Care	_ Other	_For documentation purpose only	
OUTCOME	___ Substantiated	___ Unsubstantiated	___ Unable to Substantiate	___ Other			