Lincoln County
Health and Human Services

For Dept. Use only

GRIEVANCE OR COMPLAINT FORM

This form may be submitted to any Lincoln County Health & Human Services office or mailed or faxed to:

LCHHS Executive Assistant
36 SW Nye St, Newport, OR 97365
Fax: 541-574-6252

Received by Executive Assistant:

For help completing this form, you may contact our office.

Please print clearly: Name of person with the complaint:			Phone/TTY number Email:
Mailing Address			Date of Birth
City:	State	Zip:	Preferred method of contact

Are you filing on behalf of someone else? ☐ Yes ☐ No

Your name _____ Phone: _____

Please mark the reason for your complaint

- ☐Poor customer service;
- ☐Concerns about the quality of the care received;
- ☐Information was not kept confidential;
- ☐Discrimination.

Who was involved?	When did the incident happen? Date/time:

Location of complaint or incident:

Please describe the complaint (attach additional paper if needed):

Please list any suggestions on how to prevent this from happening again.

Signature: _____ Date: _____

For LCHHS Use Only: Date Received	Received by (print name):

Grievance received via: ☐walk-in ☐phone ☐voicemail ☐email ☐letter ☐other:_____

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GRIEVANCE RESPONSE

Received by Director/ Deputy Director on Date:	Acknowledgement Letter Sent on Date:
Investigation Completed by:	Date:
Details of Investigation:	
How was complaint or grievance resolved?	
Grievant notified of resolution on date:	By ☐Letter ☐Phone ☐Email ☐In Person

I have reviewed the response to this grievance:

Manager Name	Signature	Date
Deputy Director Name	Signature	Date
Director Name	Signature	Date

Return completed form to the LCHHS Executive Assistant.