Stark County Health Department
COMPLAINT/GRIEVANCE CLIENT/CUSTOMER POLICY

POLICY:
The Stark County Health Department (SCHD) encourages clients/customers to provide feedback about their experiences while receiving services provided by the Stark County Health Department. By obtaining feedback from clients/customers, the SCHD can identify opportunities to improve its processes, thereby enhancing client/customer satisfaction. All complaints and grievances shall be handled in a culturally sensitive and linguistically appropriate manner for the client being served. This includes, but is not limited to providing access to language assistance services and making forms available in prevalent languages. No person shall be punished or retaliated against for filing a grievance.

PURPOSE:
To provide client/customers with a mechanism for communicating a complaint or grievance and to ensure that appropriate action is taken in regard to this information.

NOTIFICATION: Client/customers shall be made aware of their ability to file a grievance through postings in common areas, on the SCHD website, and by staff members.

DEFINITIONS:
- **Complaint** - means a verbal or written expression of displeasure or dissatisfaction with service received that can be immediately resolved by the staff present.
- **Grievance -** is defined as a formal verbal or written expression of dissatisfaction with some aspect of care or service that has not been resolved to the clients/customer's satisfaction at the point of service.

PROCEDURE FOR HANDLING COMPLAINTS:
1. Any employee who receives a complaint from a client/customer shall immediately attempt to resolve the complaint within that employee's role and authority.
2. If the complaint cannot be immediately resolved, the employee shall escalate the complaint through the appropriate chain of command.
3. The supervisor or manager shall resolve the complaint or take steps to continue the resolution process with the knowledge and agreement of the client/customer making the complaint.
4. If the complaint cannot be resolved, the client/customer will be offered the opportunity to file a "Stark County Health Department Client/Customer Grievance Form." (Link Here)

PROCEDURE FOR HANDLING GRIEVANCES:
1. If the complaint cannot be resolved, the client/customer will be offered the opportunity to file a "Stark County Health Department Grievance Form." (Link Here)
2. The form can be sent to the Administrative Personnel Coordinator or will be given to the Service Area Director in which the grievance occurred. If that Service Area Director is not available, the grievance will be given to another Service Area Director who is available. If given to the Administrative Personnel Coordinator it will be reviewed and provided to the Service Area Director in which the grievance occurred.
3. The grievance will be addressed within 7 business days. If this is not possible, the individual filing the grievance shall be notified of status of resolution to their grievance.
4. Upon conclusion of the investigation, the Service Area Director will complete a narrative on actions taken to address grievance (located on Client/Customer Grievance Form.)
5. The Service Area Director shall provide a written response to the client/customer of action steps to resolve their grievance, unless grievance was filed anonymously.
6. If the client/customer is dissatisfied with the outcome of the grievance resolution, the Service Area Director involved will consult with the Health Commissioner for final resolution.
7. All grievances shall be maintained on file by the Administrative Personnel Coordinator and shall be provided to the Health Commissioner for review on an annual basis or as needed.

STARK COUNTY HEALTH DEPARTMENT
CLIENT/CUSTOMER GRIEVANCE FORM

You may file this grievance **ANONYMOUSLY**, by **NOT** providing us your name and address. **Skip to Section II if you wish to remain anonymous**. If you remain anonymous, the Stark County Health Department will not be able to contact you to obtain additional information or notify you of the results of the grievance investigation.

Section I Complainant Information – *Complete only if you wish to receive our acknowledgement and notification letter with the results of the grievance investigation* ***Red outlined fields are mandatory**

Complainant Name:		
Street Address:		
City:	State:	Zip:
Primary Telephone: ( )	Secondary Telephone: ( )	

NOTE: All person-identifiable information is confidential.

Section II Location Information

***Service Area (check appropriate box): ☐ Administrative/Support ☐ Nursing ☐ Environmental**

*Incident Location:		
*Address:		
City:	State:	Zip
Telephone:		

Section III Alleged Wrongdoer(s) Information – if applicable or known

Name:	Title:
Additional Name(s)/Title:	
Name and Title:	
Name and Title:	
Name and Title:	

*Section IV Narrative Description

Provide a narrative description of your grievance which should include **date, time and location** of the incident. Include name and phone number of any witness(es), if applicable.

(Please include in the box on the next page)

Narrative Description:

Office use only: Administrative actions taken to address grievance:

Director Signature: _____ Date: _____

Health Commissioner Signature: _____ Date: _____

Submit this form to: Administrative Personnel Coordinator

Laurie Middleton
middletonl@starkhealth.org
7235 Whipple Ave NW. Canton, OH 44720

Form Reference: Adapted from ODH- HEA1685 on 1/7/18