Grievance Procedure

Drug Abuse Treatment Association, Inc. (DATA) is dedicated to providing the highest quality of services to our clients. We believe that to accomplish this, we must provide forums for our clients, staff, and stakeholders to provide us feedback. The grievance procedure was developed to establish a method of addressing issues and/or concerns that cannot be resolved informally between you and agency staff. ***You have the right to file a grievance at any time without fear of retaliation, reprisal, retribution, or barriers to service.*** This allows you to grieve the actions of program staff and your peers, as well as, decisions, conditions, or circumstances which you feel have violated your rights.

The leveled Grievance Procedure and Client/Staff Rights & Responsibilities are as follows:

Phase I: This phase is an informal grievance appeal. In this phase, you will attempt to resolve the complaint or situation with the staff on duty at the time of the grieved situation. Sometimes this process may resolve the situation and prevent a more formal complaint. You do understand that if you are suffering programmatic consequences that this action shall not alter your status just by filing the grievance.

Phase II: If you feel that the complaint/condition has not been resolved to your satisfaction in Phase I, you will submit, in writing, your complaint to the supervisor within 24 hours. You understand that at this point the Program Supervisor has 48 hours to respond to your grievance in writing. During that time, the Program Supervisor will review the complaint to see if, in fact, your rights have been violated, or if you have been treated unfairly. The Program Supervisor will correct any actions that are found to be in violation of your rights or inconsistent with policy and/or procedure. If you are not satisfied with the decision or actions of the Program Supervisor, you have the right to pursue Phase III.

Phase III: If you do not agree with the solution in Phase II, you will complete the written request to have your grievance submitted to the Chief Operating Officer (COO). Your appeal will be reviewed within 24 hours (Monday through Friday). The COO will hold a formal hearing with those parties involved. The COO will respond to all parties in writing of their findings within 24 hours of the hearing.

Phase IV: If you are still not satisfied with the findings and responses in Phase III, all statements, findings, and decisions will be forwarded to the Chief Executive Officer (CEO). The results will be presented in writing to all parties within 24 hours of receipt of this information. This phase will result in the final decision.

Phase V: If you are still not satisfied with the findings in Phase IV, or you feel your rights have been grossly violated, you have the right to contact:

Florida Abuse Hotline	800.962.2873
Southeast Florida Behavioral Health Network	561.203.2485
Disability Rights Florida	800.342.0823
DCF SA/MH Program Office: Circuits 15 & 19	561.227.6680
DCF Office of Civil Rights	850.487.1901
Agency for Health Care Administration	888.419.3456
US Department of Justice	888.736.5551

By signing below, you acknowledge that you understand the procedure and attest that you have been advised of this procedure upon admission to the program as part of your orientation. You also understand that if necessary, you may have an advocate available for assistance with this process at any time. If there is any part of this process that you do not understand or you would like more information, you may go to any staff member for assistance. The completed and signed Grievance Form may be turned in to any staff member to whom you feel comfortable. Or, you may mail it to Drug Abuse Treatment Association, ATTN: Chief Compliance Officer, 1016 Clemons Street, Suite 300, Jupiter, FL 33477.

_____

Client Signature Date

_____

Staff Signature Date

DATA
DRUG ABUSE TREATMENT ASSOCIATION, INC.

Grievance Submission Form

Your Name: _____ **Staff Involved:** _____ **Date Submitted:** _____

Program: ☐ School-Based Program ☐ In Home Services ☐ Outpatient ☐ Kelly Center ☐ Hayslip Center ☐ Other: _____

Date of Incident: _____ **Time of Incident:** _____ **Location of Incident:** _____

In as much detail as possible, including possible witnesses, how did the incident occur? _____

_____

_____

_____

_____

_____

What did the staff member say occurred? _____

_____

_____

_____

_____

_____

What steps did you and the staff member take to resolve this matter? _____

_____

_____

_____

_____

_____

What is your proposed solution? _____

_____

_____

_____

_____

_____

By signing this form, I certify that the above is true to the best of my knowledge and my discussion with the staff member identified above did not resolve my grievance. I also understand that the Program Supervisor will respond to my grievance in writing within 48 hours *(excluding weekends)*.

_____

Signature Date

★ ***When completed, place the form in the grievance box for management review***. ★

Rev. 7.2018