GRIEVANCE PROCEDURE

All persons, regardless or race, ethnic origin, economic status, sexual orientation or religious affiliation, will have access to services at CAN Community Health, Inc. CAN agrees to comply with the provisions or Title VI or the Civil Rights Act. It is CAN's policy that all complaints are resolved in a multi-layered manner, beginning at the lower level. Every effort will be made to resolve VERBAL complaints or appeals as soon as possible. **All grievances will remain confidential** and there shall be no reprisal towards the clients when grievances are made.

1. All complaints, verbal or written, should be directed to the clinic Practice Administrator who will work closely with the employee delivering the complaint to provide appropriate direction and supervision. The Practice Administrator will observe the employee's performance, then discuss his/her/their findings with the client. All complaints, verbal or written, shall be acknowledged within 2 business days.
2. The Practice Administrator will notify the Sr. Director of Clinical Operations.
3. Discussion of the problem between the client and Practice Administrator shall occur and a resolution presented within 10 business days.
4. If the client is unsatisfied with the results of the discussion or meeting, the client may request a hearing with the Director of Clinical Operations.
5. Any client or potential client who has a grievance may file a WRITTEN complaint to the Director of Clinical Operations addressed to the CAN Community Health, Inc. headquarters location:

   CAN Community Health, Inc.
   Attn: Sr. Director of Clinical Operations
   4440 Fruitville Rd.
   Sarasota, FL 34232

6. Discussion of the problem between the client and the administrator of his/her/their designee shall occur within 30 days of the original written report.
   a. Clients may further appeal pursuant to respective state statutes
   b. Grievances regarding Ryan White funded services may also be registered in the client's county of residence, local social services, and/or local county health department of those funds.

Client Signature _____ Client Printed Name _____ Date _____

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 12/15/2020