



EXTERNAL COMPLAINT FORM

To make a complaint, please complete all sections of this form and send it to us by regular mail, courier or FAX. See **Page 4** for details.

If you were not satisfied with the care or healthcare experience provided by CMHA, North Bay and District, you can file an external complaint after you have attempted to resolve your complaint directly with your caregiver or the Organization.

1. Contact Information

| | | | |
|---------------|-------------|---------------------------|-------------|
| First Name | Last Name | Preferred Name (Optional) | |
| Street Number | Street Name | Apt. or Suite # | |
| City | | Province | Postal Code |
| Telephone | | Email (Optional) | |

Are you making this complaint on behalf of someone else? YES NO

If YES, please provide the following information about the (former or current) resident or client. If NO skip to Section 2: Contact Preferences

| | | | |
|---------------|-------------|----------------------------|-------------|
| First Name | Last Name | Preferred Name (Optional) | |
| Street Number | Street Name | Apt. or Suite # (Optional) | |
| City | | Province | Postal Code |

Did the (former or current) resident or client ask you to make this complaint?

YES NO

Is that person deceased? YES NO

2. Contact Preferences

| | | |
|--|--------------|-------------|
| Preferred contact method: | | |
| Telephone | Regular Mail | Email * |
| * Note: CMHA, North Bay and District cannot guarantee the privacy or security of information shared using email. By selecting this option, you confirm that you understand and accept the risks. | | |
| Please check preferred language: | | |
| English | French | Other _____ |
| Please identify any required accommodations. | | |
| TTY device | Interpreter | Other _____ |

3. Health Organization Information

| | | | |
|---|----------------|---|--------------|
| Organization Name: | | | |
| Street Number | Street Name | Site (Optional) | |
| City | | Province | Postal Code |
| Telephone | | Email (Optional) | |
| Please check type of service: | | | |
| Case Management | Housing | Specialized Housing | Other |
| Do you have contact details for the person at the Organization that dealt with your complaint? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| <i>If yes, please provide the following information about the person you had contact with at the organization.</i> | | | |
| First Name | Last Name | Position or Title and Department (Optional) | |
| Telephone | | Email (Optional) | |
| Is there another health organization involved that you are also concerned about? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide the name. _____ | | | |

4. Complaint Details

Please describe your complaint. Tell us what happened; who was involved; when and where it happened; when you became aware of the problem; the main issues with which you are concerned. Feel free to continue using additional pages.

What would you like to happen to resolve your complaint? For example, an apology, additional information, change to a policy, etc.

Did you attempt to resolve your complaint directly with the Organization?

YES NO

If yes, please describe what resolution(s) the Organization suggested.

Suggested Resolution:

Did you complain to another organization or person?

YES NO

If yes, please provide the name.

5. Notice of Collection

If you are a caregiver or another person making a complaint on behalf of a client or resident, we need the consent of the resident or the client's substitute decision-maker so that we can collect the resident or client's personal and personal health information in this form.

I assert that I have the consent of the resident or the client's substitute decision-maker whose care or health care experience I have described in this form to disclose this information to CMHA, North Bay and District and staff of CMHA, North Bay and District who require it.

| | |
|---------------------------------|--------------------|
| Signature of Complainant | Date Signed |
|---------------------------------|--------------------|

Once you have completed and signed this complaint form, please send it to our office using one of the methods below.

(a) Mail or courier to:

CMHA, North Bay and District
222 Main St. East
North Bay, ON P1B 1B1

(b) FAX to:

705-495-3585

If you are having difficulties completing the form or have questions, you can contact us Monday to Friday, 9 a.m. to 3 p.m., at 705-476-4088 or 1-844-476-4088. We are here to help.