Jean Tweed Assessment Package

The Jean Tweed Centre is a community-based agency providing a wide range of services to women with substance use, gambling or mental health concerns.

Enclosed is our revised assessment package for the Centre's three week Live-in and Day Substance Use and/or Gambling programs. The package includes:

The Jean Tweed Centre Assessment (p. 2) —to be completed by the referring addiction counsellor

The Jean Tweed Centre Client Agreement (p. *12)*—this agreement covers key areas such as confidentiality and privacy

Emergency Contact (p. 14)

Release of Information (p. 15) — to be completed for significant collateral contacts (i.e. referral, psychiatrist, methadone/suboxone doctor and dispensing pharmacy if applicable)

Medical Data Sheet (p.16) - to be completed by your client's physician; please note that the medical data sheet includes a statement of consent which your client will need to sign for the information to be released

Information for your client about the Centre's Feedback and Complains Process (p.18)

When sending a referral, please also include the assessment form(s) noted in the chart below, depending on whether your client has a substance use, problem gambling, or concurrent concern:

Nature of Concern:	**Required assessments:**
Substance use only	JTC Assessment
Problem gambling only	OSAB, SOGS, BASIS and JTC assessment
Substance use and problem gambling	OSAB, SOGS, BASIS and JTC assessment

Once we receive your client's full referral package our Intake Counsellor will contact you to advise receipt of the documents and your client's name will be added to the next available **Wait List.**

Closer to the admission date, our Intake Counsellor will contact your client to review her assessment. Please note that we can only provide a confirmed admission date after speaking with her directly.

Should you require further information, please do not hesitate to contact us at (416) 255-7359.

The Jean Tweed Centre Assessment

The Jean Tweed Centre recognizes and values the rich diversity of Canadian society and specifically the communities of women, children and families it serves. We are committed to working from an inclusive, holistic anti-oppression framework to assist women from various cultures, racialized groups, abilities, socio-economic backgrounds, sexual orientation, and gender identities with their substance use, mental health, and gambling concerns.

First Name:	Last Name:	Date of Birth: (dd/mm/yyy)
Gender:	Last Name at Birth:	Health Card #:

What is your current place of residence?

Homeless/on street	Shelter/hostel	Couch surfing/staying with friend
In rooming/boarding home	Supportive/ transitional housing	Group home
Private house/apartment	Social/subsidized housing	Treatment facility/hospital/jail

Street Address:		Apt.	City:
Province:	Postal Code:	Address effective date: (dd/mm/yyyy)	Current location if different from above:

Home Phone #:	Okay to call? Yes No	Okay to leave message? Yes No	Okay to send text msg? Yes No
Other Phone #:	Okay to call? Yes No	Okay to leave message? Yes No	Okay to send text msg? Yes No

When leaving a voicemail or message with someone, may staff identify themselves as calling from Jean Tweed?
Yes No

E-mail address:	Okay to email? ☐ Yes ☐ No	Note: Privacy and security can not be guaranteed via email. We use e-mail to schedule appointments and we avoid sending sensitive information via e-mail.

Emergency Contact:	Relation:
Home Phone #:	Other Phone #:
In which of Canada's Official Languages are you most comfortable receiving your healthcare services? English French:	What is your mother tongue? English French Other
Ethnicity Choose an item.	In which language are you most comfortable receiving your healthcare services? * Choose an item.

Level of Education Complete: Income Source: Employment Status: Occupation:

Referring Source Agency Type/Name:	Phone #:	Agency Contact:

Referral Date:	Main Client: Yes No	Readmission: Yes No

Family physician: Does not have a family physician	Address:	Phone #:
Number of emergency department visits in the last 12 months:	Reason for emergency department visit(s):	
Number of overnight hospitalizations in the last 12 months (including for physical problems):	Reason for most recent hospitalization:	

Pregnant: Yes No	If yes, due date:	Birth plan:

Diagnosed with a mental health concern by a qualified mental health professional…	…within the past 12 months? Yes No	…within lifetime? Yes No
Most recent diagnosis #1:		
Most recent diagnosis #2:		
Hospitalized due to a mental health concern…	…within the past 12 months? Yes No	…within lifetime? Yes No
Currently receiving counselling/ support/ treatment for a mental health, emotional, or behavioural concern? Yes No?	If yes, please provide name of service provider:	Phone # of service provider:
Received counselling/ support/ treatment for a mental health, emotional, or behavioural concern… Please describe the concern:	…within the past 12 months? Yes No	…within lifetime? Yes No

List all **prescribed** medications/ vitamins and their purpose(s):

Methadone/opioid substitution: Yes No

Physical/Mobility/Assistive Devices

Any challenges with…	…vision? Yes No	…hearing? Yes No	…mobility? Yes No (walking or using stairs)
If you answered YES to any of the above, please describe.			
Do you use an assistive device? If yes, please describe.			

Do you have any allergies including food and pet allergy? Yes No If yes, are any of these allergies life threatening? Yes No If yes, please explain Do you have an Epi-pen prescribed? Yes No Note: if these allergies are life threatening, and if attending the day/ residential program, medical confirmation and recommended treatment (i.e., Epi-pen) from a physician is required.
Any other health concerns you think we should be aware of? Please describe.
Any history of Seizure? Please provide date of last seizure.
Any history of falls? Please provide details.
Did you experience difficulty with learning in school? Please describe.

Have you ever been diagnosed with a learning disability? Yes No	If yes, please describe:
Do you have any concerns with reading and/or writing in English? Please describe:	

Have you ever experienced any of the following in the past 12 month?			
Issue	Yes	No	Please describe (e.g., coping strategies, safety plan/ willing to contract, etc.)
Tension/ anxiety/ nervousness			
Depression			
Difficulty sleeping			
Drowsiness			
Fears/ Phobias			
Feeling that people are against you or trying to harm you			
Feeling aggressive/ violent towards others			

Ability to focus/ paying attention for long periods of time ex for an hour?			
Any difficulties with understanding written materials			
Any difficulties in learning in groups/social/community settings			
Any experience of brain injury/loss of consciousness/concussion			
Self-harm behaviour			When? How?
Thoughts of suicide			
Suicide attempt(s)			If yes, when?
Financial concerns			When?

Have you experienced any eating concerns (past and/or present) such as anorexia, bulimia, compulsive overeating, laxative abuse, etc.? If yes, how recently?

Legal/Justice Information

Mandated to attend program? Yes No If yes, by whom?	Recommended to attend? Yes No
Do you current have any legal issues? Yes No	PO/Bail officer contact info:

If yes, please describe (e.g., awaiting trial/ hearing/ sentencing, probation/ parole/ bail) & dates:

Nature of the Charge(s):	Conditions, if any:
Probation/ Parole start date (dd/mm/yyyy): Probation/ Parole end date (dd/mm/yyyy):	Pending court dates (dd/mm/yyyy):

Have you had past legal involvement? If yes, nature of the charges:

Sexual Orientation & Gender Identity

If there anything you would like us to know regarding your sexual orientation and/or your gender identity that would help us in providing you with high quality care?

Family/Social Relationships

If you have children, please list below:

Name	Gender	Age	If you child is under 16 years of age, who has legal custody?

If your child(ren) is(are) less than 16 years old, is child welfare services involved in their care? Yes No If yes, please explain (length of involvement, contact information for worker):

Are you in a relationship at the present time? Yes No If yes, length of time of relationship:

Past significant relationship(s)? (names are not required) Yes No Please describe:

Is, or was, substance use and/or gambling an issue for anyone in your family? Yes No Please describe:

Does anyone in your family have past/present issues with their mental health? (no names to be recorded)

Do you have significant support from family/ friends/ community? Please comment.

Substance Use History (if applicable)

Note to referrals: This chart is a supplement to the Admission Discharge DHQ/GAINQ3 Diagnostics Impressions Report and is required for all clients entering the Day/ Residential Program

Primary substance:				Secondary substance:		
Substances used that are currently problematic:	Frequency in past 30 days: • Did not use • 1-3x/mth • 1-2x/wk • 3-6x/wk • Daily • Binge	Date of last use (dd/mm/yyyy)	Approximate length of use (# of months/ years)	List *all* other substances currently being used	Frequency in past 30 days: • Did not use • 1-3x/mth • 1-2x/wk • 3-6x/wk • Daily • Binge	Date of last use (dd/mm/yyyy)
1.				1.		
2.				2.		
3.				3.		
4.				4.		
5.				5.		

Non-medical injection drug use? Never Prior to 1 year Past 12 months Unknown

Comments:

Gambling History
(TO BE COMPLETED FOR ALL CLIENTS, EVEN IF THERE ARE NO CONCERNS WITH GAMBLING)

Is gambling a concern for you? Yes No

Please check all gambling activities in which you engaged in the past 12 months (**regardless of concerns with playing**). Please also indicate, beside the applicable activities, those that are considered a problem, the pattern of playing, age of first time played, and date of last time played.

Type of activity	Played in last 12 months?	If yes, problematic?	Pattern of playing (e.g., daily)	Age first played	Date last played (dd/mm/yyyy)
Slot machines	Yes No	Yes No			
Gaming machines (other than slots)	Yes No	Yes No			
Casino card/ table games	Yes No	Yes No			
Non-casino card/ table games	Yes No	Yes No			
Horse races	Yes No	Yes No			
Sport betting	Yes No	Yes No			
Lottery tickets	Yes No	Yes No			
Instant win/ scratch tickets	Yes No	Yes No			
Internet gambling	Yes No	Yes No			
Gambling with stock market/ real estate	Yes No	Yes No			

Betting on games of skill	Yes No	Yes No			
Betting on outcome of events	Yes No	Yes No			
Other (please specify):	Yes No	Yes No			
Unknown/ data not available	Yes No	Yes No			

Comments:

Have you ever been concerned about your use of technology (such as internet gaming, social media, or online shopping)?
Yes No If yes, please describe:

For referrals to the Problem Gambling Program: (please include completed form with package)	OSAB Gambling Form Completed? Yes No

Do you smoke/use tobacco? Yes No	If yes, are you interested in making a change? Yes No

What support/ services have you accessed for your substance use and or gambling? (e.g., dates, # of times, etc.)

What role has substance use and/or gambling played in your life (both positive and negative)?

Past Experiences

Some women have noticed a connection between their substance and/or gambling use and traumatic experiences (i.e. emotional, physical and sexual abuse, neglect, natural disaster, loss of culture, loss of custody of a child etc...)

Have you had similar experiences that you think are important for us to know about? (description not required)

Are you currently being affected by these experiences? (flashbacks, nightmares, losing time, reactions to sudden noises etc.)? If so, how often?

What do you find helpful in dealing with these effects?

If applicable, are you still in contact with the person(s) who harmed you?

Are you grieving the loss of someone or something? If so, please describe:

Any other current stressors/life events that are impacting your substance use or/and gambling?

Please answer these questions if referring to our day/ residential programming:

Do you have a place to live upon completion of our day/ residential programming? Yes No Please explain:

Do you have any special dietary requirements? If so, please describe:

What are your plans for transportation to/ from the Centre? Please note the Centre cannot provide for the cost of transportation.

Name of your Pharmacy **Address** **Telephone #**

Name of OAT provider (if applicable) **Address** **Telephone #**

Preliminary Service Plan
Strengths: 1. 2. 3.
Coping Skills: 1. 2. 3.
Service Goals & Plans (substance use, mental health, housing, employment, etc.): 1. 2. 3.
Referrals: 1. 2. 3.
Date completed:
Completed by:

To be completed by Jean Tweed Administration

Presenting Issues:

*** Please complete this section for women who are pregnant or parenting children aged 0-6 years of age and who may be interested in parenting programs at the Jean Tweed Centre.**

Substance Use During Pregnancy			
Are you pregnant right now? Yes No			
Current pregnancy			
Substances, frequency, and method of use	1st Trimester (0-3 months)	2nd Trimester (3-6 months)	3rd Trimester (6-10 months)
For each previous pregnancy			
Substances, frequency, and method of use	1st Trimester (0-3 months)	2nd Trimester (3-6 months)	3rd Trimester (6-10 months)
For each previous pregnancy			
Substances, frequency and method of use	1st Trimester (0-3 months)	2nd Trimester (3-6 months)	3rd Trimester (6-10 months)

Please complete this section for women who are seeking admission to transitional housing programs

Transitional Program - Personal Goals

- Since completing an intensive program, what supports have you put in place?

- What would you like to accomplish while residing in the transitional program (ex related to substance use, supportive housing, employment, education, child reunification, finances, personal growth, etc.)

    1.

    2.

    3.

- A case manager will work closely with you on your short- and long-term goals. This includes establishing a plan, and regular check-ins. Are you comfortable with this? What kind of support would you like from your case manager?

Transitional Program – Community Living:

- Have you lived in a communal setting with others before? What was it like for you?

- How do you handle conflict? What would you do if you had a disagreement with another resident?

- How do you handle feelings like anger, being upset? What strategies have you been able to successfully use?

- Have you lived independently before? Please describe.

JEAN TWEED CENTRE CLIENT AGREEMENT

In signing this agreement, you agree to participate in Jean Tweed services as discussed with your JTC counsellor. As a client of the Centre, you have access to other Jean Tweed programs and we invite you to explore any that might be helpful to you.

As a client of the Jean Tweed Centre:

- This client agreement will be deemed valid while you are a participant in any services offered by the Jean Tweed Centre. Please note that you can withdraw this agreement at any time by telling your counsellor/case manager. Withdrawal of this agreement will result in discontinuation of Jean Tweed services.
- If there is no contact between yourself and the Centre after 90 days (or sooner, depending on the program) we will assume you have decided to terminate your service.
- Any personal information collected is kept confidential in paper and/or electronic files for a period of 10 years and then destroyed.
- We sometimes work with external/allied health service providers who may offer support directly to you, or indirectly to our clinical team. We may share relevant information with these health service providers as it relates to your care to better support you while you participate in Jean Tweed services. All health service providers (including Jean Tweed staff) are bound by the same policies/legislation regarding confidentiality and privacy.
- We ask for your consent before we share information about you with anyone outside the centre (e.g. family member, social service worker, child welfare worker, etc.). In these cases, we give your information only to the people you have agreed to, and to no one else.
- In some special situations, however, we may share your information without getting your express consent in writing first (e.g. emergency situation, if there is a risk you may hurt yourself or somebody else, if children are at risk, to those in your “circle of care”, or when required by law).
- Our clinicians have access to a provincial health information sharing system (Connecting Ontario) which allows rapid access to your complete, up-to-date and accurate health information from various health care sources (e.g. participating hospitals). We will only access your information if it is helpful to your care and you have the right to block access to your information if you choose.
- We use videoconferencing platforms such as the Ontario Telemedicine Network and Zoom to offer some of our services. We take all reasonable precautions to safeguard

your privacy in adherence with applicable privacy legislation. However, there are risks attached to the use of any internet-based service. For more information about how your privacy is protected at Jean Tweed, please see the centre's privacy flyer.

Releasing us from liability

Before we can provide you with any services, you must agree to release us from any liability or legal responsibility both now and in the future. When you sign your agreement, this means you're releasing us from all liability related to:

- any services we provide to you.
- stopping or cancelling any of our services.
- your use of our equipment, property and facilities including the outdoor play ground or the equipment, property and facilities of our partner organizations.
- If you bring your car to the Centre and/or take Jean Tweed transportation, the Centre is not liable for any accidents or injury.

Please see the Jean Tweed Centre's Privacy Policy for more information regarding how we respect and maintain your privacy.

Please sign here

If you have reviewed and agree to the above JTC Client Agreement, please sign below (please note that any reproduction of signatures below by fax and/or electronic transmission –including electronic copies - will be treated as though such reproductions are originals).

Client name _____ Client phone number _____

Client address _____

Client signature _____ Date _____

Signature of witness _____ Date _____

Program Evaluation Questionnaire

For the purposes of receiving your feedback, the Jean Tweed Centre would like to connect with you once you have completed programming. If you agree to be contacted by email and/or text message, please fill out the information below. (Note: privacy and security of email communication cannot be guaranteed.)

Please contact me by (choose one or both):

☐Email: _____
(email address)

☐Text Message: _____
(cell phone #)

☐ *Client has agreed to the above JTC Client Agreement.*

I confirm that I have explained the above consent to the client/guardian and provided the person who has signed this consent form or given verbal consent with an opportunity to ask questions.

_____ _____

Signature/Designation of Service Provider Date

The Jean Tweed Centre
JTC
For Women & Their Families

Client Name: _____

Client Number: _____

Information about your emergency contact

In this agreement, *we*, *our* and *us* mean the Jean Tweed Centre. This includes everybody who works or volunteers for the Centre, even the people who don't get paid. '*You'* and '*your'* means anyone who is getting treatment from us.

By signing this form, you agree that we can get in touch with the person you tell us about below if there is an emergency. We call this person your emergency contact. We may also share information about the emergency situation with them.

Please tell us about your emergency contact:

Name of your emergency contact: _____

Relationship to you: _____

Home phone number: _____

Business or cell number: _____

Please sign here:

Your signature:

Date: _____

Signature of witness:

Print name of witness/DATE:
Date: _____

Print name of witness/DATE:

If you're under 16 years of age, your parent or guardian must sign below

Signature of your parent or guardian: _____

Signature of witness: _____

The Jean Tweed Centre
JTC
For Women & Their Families

Your Consent to Release Personal Information
Third Party Disclosure Form

I, _____, authorize_____

(Print your name) *(Print name of person or Agency)* to disclose my personal information

consisting of:

_____

(Describe the information to be disclosed)

to:_____

(*Name and address of person/agency to which information is to be disclosed)*

_____ this

consent further authorizes _____

(Print name of person or Agency)

to disclose the information noted above to _____

(Print name of person or Agency)

for the following purposes: _____

- Your consent will be deemed valid while you are a participant in any services offered by The Jean Tweed Centre and immediately following for a period not to exceed three (3) months.

- At any time, you may withdraw your consent, either verbally or in writing. This will not affect the services you receive at The Jean Tweed Centre.

- Please note that any reproduction of signatures below by fax and/or electronic transmission –including electronic copies - will be treated as though such reproductions are originals):

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Withdrawal of consent to disclose personal health information

I,_____, withdraw my consent to disclose the information noted above effective
(Print your name)

_____.
(Date)

OR I,_____, withdraw my consent to disclose the personal information consisting of
(Print your name)

(Describe the information not to be disclosed)

Client Signature:_____ Date:_____

Address:_____

Phone number(s) where I can be reached:_____

Please provide as many details as possible. The Jean Tweed Centre will abide by the enclosed instructions where possible. All withdrawal of consent to disclose requests will be forwarded to our Chief Privacy Officer, who may contact you via telephone to review your request.

The Jean Tweed Centre
JTC
For Women & Their Families

Client No: _____

MEDICAL DATA SHEET

Dear Doctor:

Your patient has applied to the Day/Residential Program at the Jean Tweed Centre. The Jean Tweed Centre is a provincially funded non-medical program offering treatment to women with problematic substance use and/or gambling. To ensure the best care for this individual, we are requesting that you provide any relevant medical information.

Thank you for your assistance. If you have any questions, or, we can be of further assistance, please call the intake department at: 416-255-7359 ext. 227/243/260. Please fax this document when complete to 416-255-9021

Client Name:_____ DOB:_____ Date:_____

Health Card Number: _____

1. Brief Alcohol & Drug History: (any difficulty with withdrawal, seizures etc, length of use)

2. Significant Past Health History:

3. Significant Current Physical Findings:

4. Psychiatric History and Current Mental Status:

5. Please list all medications, vitamins and supplements that you approve for your patient's use:

MEDICATIONS					
NAME	DOSE/ FRQCY	COMMENTS	NAME	DOSE/ FRQCY	COMMENTS

The Jean Tweed Centre
JTC
For Women & Their Families

Client No: _____

MEDICAL DATA SHEET

6. **Communicable Infections & Immunizations:** History of Chickenpox (VZV): _____

Other: _____

7. Recent Travel History in last 6 months: _____

8. Significant Lab Findings – **please attach (actual lab reports) The following tests are required: CBC, LFT, Gamma GT, Fasting Blood Sugar** (within the last two months). If there is a history or suspected eating disorder please also include Electrolytes (K+, Na+ and Cl).

9. List ALL Known Allergies indicating severity (i.e. life threatening, airborne) and medications:

_____

If life threatening, has an epi-pen been prescribed? Yes No

10. Please list any dietary restrictions (e.g.,vegetarian, vegan, gluten intolerance, lactose intolerance), food allergies(e.g., nuts, dairy) or medical/nutritional needs(e.g., diabetes, low sodium diet) that client may have.

_____

11. The Physical building and location of our facility is limited due to steep stairs and very limited staff to support for those who require physical assistance.

a. Does your patient/client have any mobility challenges with walking or utilizing stairs?
Yes ☐ No ☐
If Yes - (describe)

b. Does your patient/client use any assistive devices such as cane, walker, wheelchair?
Yes ☐ No ☐
If Yes (describe)

c. Can your patient bathe/shower independently and safely?
Yes ☐ No ☐
If No (describe)

d. Does your patient have a hx of falls?
Yes ☐ No ☐
If yes (describe)

12. Does your patient have active physical health concerns that require homecare/nursing support (ex, wound care)?
_____

13. Has the patient been recently hospitalized in the last 2 months? Yes ☐ ☐
If yes (describe)

_____

Cognition and Alertness

14. The intensive community-based residential program requires participants to be able to attend and participate in all therapeutic groups daily for 21 days and requires participants to be able to be alert and attentive. Does your patient have any challenges with cognition and alertness?
    Yes ☐ No ☐
    If yes (describe)

15. In your opinion, is your patient medically fit to participate in this program? Yes ☐ No ☐

    Please note any concerns: _____

16. Any further comments? _____

17. Obstetrical History and Findings: **For Pregnant Patients(only)**:

    Due date:
    Physician responsible for prenatal care:

    Address:
    Phone Number: Fax Number:

    Hospital for Delivery:

    Complications of current pregnancy:

    Management Plan:

    Complications past pregnancies or deliveries:

Physician Name: **Physician Signature:**

Physician Address and Phone Number:

I hereby give Dr. permission to release the above information to (Medical Consultant for the Jean Tweed Centre) or to the Clinical staff processing receipt of admission information. I further authorize consultation with my physician in the event of a medical question or concern related to my participation in the program.

Client Signature:_____ Date _____

The Jean Tweed Centre
JTC
For Women & Their Families

How to give feedback/make a complaint

Welcome to the Jean Tweed Centre.

We have attached the feedback and complaints policy and procedure.

If you have feedback or a complaint please talk to your counselor. If you are not comfortable speaking to your counselor you can talk to a manager.

Thank you for your feedback.

Belinda Marchese
Executive Director

The Jean Tweed Centre
Clients and Community Member
Feedback and Complaints
Policy

The Jean Tweed Centre will attend to client and community member feedback and complaints. Feedback can be made by any client or community member. It can be about any program, service or practice. Feedback can be about staff, volunteers, students, clients or other people you come into contact with at the Centre. If your feedback is a complaint and you give your contact information we will follow up with you within 10 days. Complaints will be treated fairly. If you make a complaint you will not be treated unfairly.

A **Client** is a woman and/or her family that has received or is receiving services from The Jean Tweed Centre.

A **Community member** is anyone that is not a current or past client of the Jean Tweed centre. This may include family members who are not receiving services, applicants, donors or the general public. It does not include staff, volunteers or students.

Feedback and complaints will only be shared with those who need to know about them. If your complaint is about something illegal the Centre may need to share it with the authorities. The Executive Director will share serious complaints with the Board of Directors by the Executive Director. All complaints are logged and kept in a safe location.

The Jean Tweed Centre posts this policy and the procedures. A copy is posted on the website. This policy and procedures follows the rules in the Accessibility for Ontarians with Disabilities Act.

Procedures

Feedback:
You can provide feedback in person, by telephone, in writing, or by delivering an electronic text by email or otherwise. Let us know if you want us to respond or take some action.

a. In person: You can provide feedback to any staff member face-to-face or over the phone.

b. In writing: You can write down your feedback on feedback forms, in a letter or in the email on thewebsite. Some programs have satisfaction surveys that you can fill out. There is a suggestion box in the 215 Evans lobby.

You can ask for support from staff to give feedback or to make a complaint. Complaints:

Please make complaints within 10 working days of your concern if you can. We will respond within 10 days.

1. Informal Process

Speak to the person you have a concern with first unless you do not feel safe to do so.

If you are a client you have the right to speak with your counselor about the program.

Feedback about a counsellor can be directed to a manager. Clients and community members can ask any staff person to direct them to a manager.

If your complaint is not fixed informally move on to the next step.

2. Formal Process

a) Write out your formal complaint. Make sure you include details such as who is involved, where andwhen the incident occurred, what happened, why you are concerned about the incident, how to reach you. If a staff person helps you they will add their name.

Put your complaint in a sealed envelope. Write “Feedback/ complaint” with the name or title of the person you want to send it to. *For example: “Feedback/complaint– send to manager”.*
This envelope can be left with any staff member. The staff member will give it to the right person.

You can send a complaint to feedback@jeantweed.com. In the subject line write “Feedback/complaint” with the name or title of the person you want to send it to.
You can ask to meet with someone from the Jean Tweed Centre. You can put this in your complaint.

b) Someone from the Centre will answer your complaint within 10 business days. This might include ameeting. This meeting might be in person, by phone or video-conference. In some cases more time is needed.

c) Sometimes another meeting will be needed. This meeting should take place within 10 working days.

d) The Jean Tweed Centre will write a letter after hearing the complaint. This letter will be sent within 10business days. Sometimes more time is needed. The letter will include a summary of the complaint. It will include details of any follow up.

e) If you are not satisfied you can request a meeting with someone else.

Records
Your formal complaint will be kept in a secure location. Only the people who need to see your complaint will have access.

Frivolous, Vexatious Complaints
If you make a complaint that you know is not valid The Jean Tweed Centre will address this accordingly.