



Participant Grievance Form

Participant Name: _____

Initiated by: Participant Caregiver Family

Name of Initiate other than above: _____ Relationship: _____

Date Initiated: _____ The Quality Assurance Manager or designee will provide you with an initial resolution to your Grievance by: _____. It can take up to 20 business days to finalize a resolution to your Grievance.

Participant has been informed of their right to request assistance in completing this Grievance form and has received written information on the Grievance Process. Date: _____

Nature of Grievance:

Clinic Contracted Provider Day Center

Home Care Food in Center Transportation

Other: _____

State the Grievance: _____

Name of staff person assisting with completion of form: _____

Was the Grievance resolved? Y/N Date: _____

Resolution and Response:

Participant offered Copy of resolved Grievance Accept Declined Date: _____