

Bancroft NeuroHealth Grievance Form

Name of Person Served: _____ Date Filed: _____

Program: _____

Summary of Grievance: (attach separate sheet if more space is needed): _____

Routine Urgent (please explain): _____

(Please note: Safety concerns or other concerns about the health or well-being of an individual served shall be addressed by program leadership; they shall not be addressed through grievance process.)

Person Filing Appeal: _____ Date: _____
Signature

Printed Name: _____ Phone: _____

Individual Served Guardian Family Member Other
him/herself Note: _____

AREA BELOW IS TO BE COMPLETED BY FAMILY ADVOCATE.

Family Advocate Signature: _____ Date Received: _____

Actions Taken:

<u>Date</u>	<u>Action</u>
_____	_____
_____	_____
_____	_____
_____	_____

Resolution: _____

Staff Responsible for
Actions to be Taken: _____ Date: _____

Please complete top part of form and return it to the Office of the Family Advocate, ATTN: Kathy Ross, Bancroft NeuroHealth, 425 Kings Highway East, P.O. Box 20, Haddonfield, NJ 08033. If you have any questions regarding this form or the process, please call (856) 429-5637, ext. 336.