SarahCare®

Adult Day Health Centers

Grievance Form

Name: _____ Phone Number: _____

Email Address: _____

Mailing Address: _____

City/State/Zip Code: _____

Relationship to SarahCare:

___ Employee ___ Participant ___ Family Member ___ Other: _____

Please explain your grievance, providing details as appropriate:

_____

_____

_____

_____

_____

_____

_____

_____

(Continue on reverse side, if necessary.)

Please provide us with any suggestions as to how we may resolve your grievance:

_____

_____

_____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date Received:_____ Date Response Sent:_____ By:_____

Disposition:_____

_____

_____

_____