HEALTHY START SERVICES GRIEVANCE SUMMARY SHEET

Date Received: _______________ Received By: _____________________________________
Full Name and Title

____
Last Name of Grievant First Name MI

____
Address (Number, Street, Apartment)

____
City, State and Zip Code

____
Home Phone Work Phone Medicaid I.D. Number

Type of Grievance: Operational ____ Medical _____ Other____________________

Name and Telephone Number of Person or Care Provider Involved (If Applicable)

____
Name Telephone Number

Summary of Grievance: (Include Witness(es) if Applicable) _________________________

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Supervisor Notified:_________________________ Date__________ Time:___________

SupervisorReview:_________________________Date:___________Time:___________

____
Signature

Healthy Start Coalition Executive Director Notified By:___________________________

Date: ____________________Time:____________________________

Investigation and Findings: ____

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Actions taken: ____