

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 Grievance: \_\_\_\_\_ Date: \_\_\_\_\_

Signature

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Individual Served (him/herself)

Family Member

Guardian

Other \_\_\_\_\_

**AREA BELOW IS TO BE COMPLETED BY FAMILY ADVOCATE**

Family Advocate Signature: \_\_\_\_\_ Date Received: \_\_\_\_\_

**Actions Taken:**

Date

Action

Date	Action
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**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: Dan Keating, Ph.D., 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. 372.*