



CONSUMER & FAMILY GRIEVANCE/APPEAL FORM

Consumer's Name:		Date:
Birth Date (mm/dd/yy):	Relationship to Consumer:	
Consumer's Street Address:		
City, State, Zip		
Phone Number:	Message Phone:	
Service Site:		

Description of Grievance/Appeal (Please attach additional sheet, if necessary):

What have you already done to resolve this grievance/appeal?

How would you like to see this grievance/appeal resolved?

Form Completed by:	
Name:	Phone:

DO NOT WRITE BELOW THIS LINE

To be completed by BHCS Staff

RESOLUTION TO GRIEVANCE/ APPEAL

BHCS Staff:	PSP Number:
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Description of the Grievance/Appeal Resolution:

Consumer/Representative Contact:

Date:	Time:	<input type="checkbox"/> Letter	<input type="checkbox"/> Telephone	<input type="checkbox"/> Other:
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Content:

Date:	Time:	<input type="checkbox"/> Letter	<input type="checkbox"/> Telephone	<input type="checkbox"/> Other:
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Content: