YOLO ADULT DAY HEALTH CENTER

GRIEVANCE REPORT

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Grievance Reported By: _____ Date of Grievance: _____

CLIENT COMMENTS

_____

_____

_____

_____

_____

_____

_____

INITIAL RESPONSE

Name: _____ Date: _____

RESOLUTION

Name: _____ Date: _____