Consumer Grievance Form

Directions: Please complete all fields of this form. This information will help us in addressing the grievance and responding back to you in a timely manner. Please give this Grievance Form to the Clinical Director or mail to the attention of:

Turning Point Family CARE
Attn: Quality Management Director
3509 Haworth Drive, Suite 105, Raleigh, NC 27609

Date of Grievance: _____ (date event occurred)

Name of Individual(s) Filing Grievance: _____

Phone Number(s): _____

Address(es): _____

Grievance: Please give detailed information (dates, times, staff member names, and specific concerns.) *You are welcome to write on the back of this page or submit additional pages.*

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Signature: _____ Date: _____

TO BE COMPLETED BY TURNING POINT FAMILY CARE ONLY

Date Received by TPFC: _____ Staff Signature: _____

Date forwarded to Compliance Officer: _____ Date of Management Team Meeting: _____

Date of Resolution presented to client: _____ Resolution accepted ☐Yes ☐No

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