ROOTS
HEALTHCARE SERVICES

Participant/Family Grievance Form

Name of Participant:_____
(Optional)

Rehabilitation Counselor:_____

Please describe your complaint/grievance

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Date and names of witnesses involved

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Today's Date:_____

Your Phone Number(s):_____

Please email completed form to rootshcs@outlook.com, or mailed to our Program Director Omela Francis-Alman LCSW-C 104 Plumtree Rd Suite 103 Belair MD 21015. Please note that email is the most efficient method and will allow for the quickest response from us.