Grievance Form

Arizona Care Services

Personal Information (please print or type)

Caregiver		Service Received		
Last Name	First Name		MI	Date of Birth
Address	Apt #	City	State	ZIP
Home Telephone ( )		Work Telephone ( )		Extension

If someone other than the member is filing this grievance, please provide the following information:

Name		Daytime Telephone ( )		
Relationship to Member				
Address	Apt #	City	State	ZIP

Describe Your Grievance

Please describe your complaint. Be sure to include specific dates, times, names, place, etc. that were involved. Please send copies of anything that may help us understand your grievance to the address listed below or fax the documents to (480) 630-2066.

Signature

Your Signature	Date
Signature of Representative	Date

Please sign and mail or fax to:

ATTN: Grievances Department
7349 N Via Paseo Del Sur #442
Scottsdale, AZ 85258

FAX: (480) 630-2066