Florida Institute of Technology
The Scott Center for Autism Treatment

GRIEVANCE/COMPLAINT

A) PERSON OR ENTITY FILING THE COMPLAINT:

First Name_____Middle Initial_____Last Name_____

Organization, Title (if an Entity) _____

Street Address _____

City _____ State_____ ZIP_____

Work Number _____ Extension_____ Alternate Number _____

Email address _____

GRIEVANCE ADDENDUM:

Classification: ❑ Quality of Care ❑ Quality of Service ❑ Complaint

Category: *(check all that apply)* ❑ Access to Services ❑ Attitude ❑ Billing/Cost ❑ Cleanliness ❑ Clinical Quality ❑ Communication ❑ Coordination of Care ❑ Delay ❑ Miscellaneous ❑ Noise ❑ Policy/Procedure ❑ Privacy/Confidentiality ❑ Property

B) INFORMATION ABOUT THE ENTITY YOU ARE FILING A COMPLAINT ABOUT:

The Scott Center for Autism Treatment and _____
Name of individual (if applicable)

Covered Entity Contact Person:
Dr. Barbara Paulillo or Dr. Michael Kelley
The Scott Center for Autism Treatment
150 W. University Blvd., Melbourne, FL 32901

C) PROVIDE COMMENTS ABOUT YOUR SPECIFIC COMPLAINT(S) BELOW:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature _____Date_____

ADMINISTRATIVE USE ONLY

Received By_____Date_____

Follow-Up _____

Resolution_____