Deaf and Hard of Hearing Service Center

CLIENT GRIEVANCE FORM

In accordance with our Client Grievance Policy, all persons receiving services, directly or indirectly, from DHHSC, have the right to file a grievance for unsatisfactory services rendered. In an effort to address and respond to your specific concern, please complete the following information as thoroughly as possible.

Your Name: _____

Address and/or Phone Number: _____

Date Grievance Form was completed: _____

Have you read and understand our Client Grievance Policy? Yes No

To which staff member is your grievance against? _____

Have you attempted to address your grievance with the above named DHHSC staff? Yes No If yes, when? _____

Please explain in as much detail as possible the reason for your grievance?

_____
_____
_____
_____
_____
_____
_____

(please use additional pages if necessary)

Thank you for taking the time to complete the above information. DHHSC will be contacting you within 14 business days to attempt to resolve the above expressed complaint and/or concern.

For Office Use Only:

Grievance Received by: _____ Date: _____

Above Situation was discussed with: _____

DHHSC responded to client on (date) _____

Detailed description of how grievance was resolved. If not resolved, what options were presented to client?

_____
_____
_____

DT Y/N CGF – Revised: 11/18 JL