

**Deaf and Hard of Hearing Service Center, Inc.**

**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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_