Client Compliment / Complaint Form

DHHSC is interested in hearing your comments

Date: ____________
Name (optional): ____________________________________

Which City do you live in? ________________________________

1.) Are you:

☐ Deaf
☐ Hard of Hearing
☐ Late-Deafened
☐ Deaf-Blind
☐ Hearing

2.) Was DHHSC Staff...

Helpful and ready to serve you? ____________________________
Friendly and respectful? ________________________________
Professional? ____________________________

3.) Did DHHSC Staff...

Explain services well? ________________________________
Communicate clearly? ________________________________
Provide appropriate resources? ____________________________
Provide adequate answers? ________________________________
Provide needed services? ________________________________

4.) Will you...

Use DHHSC services again? ________________________________
Tell others about DHHSC's services? ________________________________

If you answered "sort of" or "no" to any of the questions above, please explain:
________________________________________________________
________________________________________________________