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...

	Yes	Sort of	No
Helpful and ready to serve you?			
Friendly and respectful?			
Professional?			

3.) Did DHHSC Staff...

	Yes	Sort of	No
Explain services well?			
Communicate clearly?			
Provide appropriate resources?			
Provide adequate answers?			
Provide needed services?			

4.) Will you...

	Yes	No
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:

_____

_____