



**GRIEVANCE FORM**

CLIENT NAME \_\_\_\_\_

INDIVIDUAL FILING GRIEVANCE \_\_\_\_\_

RELATIONSHIP TO CLIENT \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

**Describe your problem. Tell us how you were denied a service or benefit or your rights or privileges have been limited or denied.**

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**What do you want done?**

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Person(s) involved in grievance \_\_\_\_\_

The above information is true and correct. I have been unable to resolve my problem described above.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please submit to Coordinator of Training and Quality Assurance.