THE CENTER FOR FAMILY SERVICES

Grievance Form

Date: ____/____/______ Location: ____

Name of Complainant: ____

Telephone Number: (H) ___________________________ (W) ________________________

Address: ____

Okay to leave message? H: ___ yes ___ no W: ___ yes ___ no Okay to send mail? ____ yes ____ no

Nature of Complaint:

- ☐ call wasn't returned
- ☐ misinformed (explain under comments)
- ☐ waiting period too long for appointment
- ☐ poor service (explain under comments)
- ☐ would like to change therapist (explain under comments)
- ☐ other ____

*Comments:*____

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Taken By: ____

- ☐ Route to Chief Operating Officer
- ☐ Copy to Program Director
- ☐ Copy to Executive Director
- ☐ Copy to Director of Finance/Administration (if applicable)
- ☐ Copy to Director of Support Services (if applicable)
- ☐ Copy to Client File

Recommended Follow-up

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SIGNATURE: ____ DATE: _______________