



Client Grievance Form

Client Information: <hr/> Name <hr/> Address <hr/> City _____ State _____ Zip _____ (_____) _____ Phone with Area Code _____	Information about the grievance (if applicable): Date: _____ Time: _____ Location : _____ If Transcribed by an Employee - Employee Name: _____
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Indicate the Program Associated With the Grievance:

<input type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Adoption or Pregnancy Counseling
<input type="checkbox"/> Emergency Services	<input type="checkbox"/> Representative Payee Program
<input type="checkbox"/> Financial Counseling	<input type="checkbox"/> In Home Support Program
<input type="checkbox"/> HIV/AIDS Ministry	<input type="checkbox"/> Immigration Services
<input type="checkbox"/> Domestic Abuse Prevention	<input type="checkbox"/> Other _____

Name the Employee That You are Working With:

Briefly Describe the Nature of Your Grievance:

How Would Like Us to Resolve This Issue?

Forward Report to the Client Rights Specialist:
 Client Rights Specialist
 Catholic Charities of the Diocese of La Crosse
 448 N. Dewey Street
 Eau Claire, WI 54703

For Agency Use:

Date Program Supervisor or Executive Director Notified: _____

Date Response Provided to Client: _____

Agency Action: Indicate actions taken to address the issue including follow up dates:
