SHEBOYGAN COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT
GRIEVANCE/COMPLAINT FORM

Name of Person Making the Complaint:

Address of Person Making the Complaint:

City, State, Zip:

Telephone Number of Person Making Complaint:

PLEASE COMPLETE THE FOLLOWING IF YOU ARE COMPLAINING ON BEHALF OF SOMEONE ELSE:

Consumer Name:

Consumer Address:

City, State, Zip:

Consumer Telephone Number:

Relationship to Consumer:

DESCRIBE YOUR COMPLAINT: Describe the action or treatment which is the basis of your complaint. Include information about who, what, when, where, how and why and the names, addresses, and phone numbers of any witnesses, if you know them. Please be specific about the date of the last incident.

BRIEF DESCRIPTION OF THE RELIEF OR SATISFACTION YOU ARE SEEKING:

Signature: Date:

Please ask any staff member for assistance if you would like help in filling out this form.

When form is complete, you can: 1.) hand into any HHS staff member
2.) email to the address: human.services@sheboygancounty.com
3.) mail to: Grievance Coordinator
1011 N. Eighth Street
Sheboygan, WI 53081

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TO BE FILLED OUT BY HHS STAFF:

Date Complaint Received:
By Employee (Name):