GRIEVANCE FORM

The goal of this document is to help us ensure that we understand your grievance and can respond promptly. Please complete this form and return to:

Aging and Disability Resource Center of Jackson County
Attn: Aging and Disability Services Manager
421 County Road R
Black River Falls, WI 54615

Reporter's Name	
Reporter's Phone#	
Reporter's Address	

If you are filing the grievance on behalf of another individual, please provide:

Client's Name	
Client's Phone#	
Client's Address	

PLEASE DESCRIBE YOUR GRIEVANCE: Please be as specific as you can. Include any names or dates, as this may help resolve your grievance. You can use the back of this form or attach additional information to describe your concerns. You can also request assistance in completing this form from our staff.

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HOW YOU WOULD LIKE TO SEE YOUR GRIEVANCE RESOLVED:

_____ _____

Your signature Date