

**SENIORS AND PEOPLE WITH DISABILITIES
STATE-OPERATED COMMUNITY PROGRAM
CLIENT GRIEVANCE REPORT FORM**

Initial Report Subsequent Report, Step _____
(Circle one)

Client Name:	Residence:
Name of Person Acting in Clients Behalf, if any:	
Date of Grievance/Complaint:	Time: AM PM
_____ Signature of Staff Receiving Initial Grievance/Complaint	
Specific details of Grievance: _____	

Resolution/Findings of Initial Grievance: _____	

Client/Client Representative Acceptance of Resolution: YES NO	
_____	_____
Client Signature	Date
_____	_____
Staff Signature	Date
_____	_____
If no, staff member and Client/Client representative will refer a copy of this Grievance Report to _____, representing the next step in the Grievance Procedure.	