

**EAU CLAIRE COUNTY DEPARTMENT OF HUMAN SERVICES
COMPLAINT SCREENING FORM**

Complainant: _____ Phone #: _____

Street Address: _____

Alternate phone #: _____

Mailing Address (if different): _____

Best time to call: _____ can a message be left on machine? _____

City: _____ State: _____ Zip Code: _____

Client (if not complainant): _____ Phone #: _____

Street Address: _____

Alternate phone #: _____

Mailing Address (if different): _____

Best time to call: _____ can a message be left on machine? _____

City: _____ State: _____ Zip Code: _____

Services Received at the Department:

- _____ Employment and Economic Resource Unit
 - _____ W-2
 - _____ Food Stamps/Medical Assistance
 - _____ Energy Assistance
 - _____ Child Care
 - _____ General Relief
 - _____ Other

Name of Financial Employment Planner/Staff: _____

- _____ Family Services Unit
 - _____ Intake
 - _____ Case Management
 - _____ Foster Care Licensing
 - _____ Birth to 3

Name of Social Worker: _____

- _____ Adult Services Unit
 - _____ Intake
 - _____ Case Management
 - _____ Community Support Program

Name of Social Worker: _____

I am receiving services for: (please check all that apply)

- AODA
- Developmental Disability
- Mental Illness

Name of Social Worker: _____

Other - please specify: _____

Please briefly state your complaint: _____

Is this complaint against a specific staff person? _____. If so, please name:

Relief sought: _____

Signature

Date