



COMPLAINT FORM

Client Name: _____ Date: _____

Client Address: _____ Telephone: _____

Employee Name (if known): _____ Case Number (if known): _____

Check Program:

- | | | |
|---|---|---|
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Alaska Temporary Assistance | <input type="checkbox"/> Heating Assistance |
| <input type="checkbox"/> Denali KidCare | <input type="checkbox"/> Adult Public Assistance | <input type="checkbox"/> Senior Benefits |
| <input type="checkbox"/> Denali Care | <input type="checkbox"/> Chronic and Acute Medical Assistance | <input type="checkbox"/> General Assistance |

Type of Complaint:

- Change processing delayed more than 10 days
- Rude/inconsiderate/belligerent employee: employee name: _____
- Delay in benefits/non-receipt of benefits
- Long wait to apply – Specify length of time: _____
- Was not informed or was misinformed
- Agency lost change report, application, or other form
- Unable to make contact with office/ET
- Other: _____

Details of Complaint

Client Signature: _____ Date: _____

Important: This complaint form will be forwarded to the regional manager for evaluation to both the extent and trends of problem areas, which may need corrective action. Completion of this form will not involve you in a hearing.