HISPANIC FAMILY COUNSELING, INC.

GRIEVANCE REPORT

Client's Name:_____ Relationship to Client:_____

(1) Individual filing the grievance:

☐ Client

☐ HFC staff on behalf of client
☐ Family Member (please complete (2))
☐ Client's representative (please complete (2))

(2) Name and Contact Information:
(if other than Client or HFC Staff)
(Name/Relationship to Client)

(Address)

(Telephone)

Please provide a complete description about your grievance:
What happened? Who was involved? What date did the event occur? Where did the event occur? If you need more space, please attach additional pages. Check box if additional pages are attached ☐.

Signature of Person Reporting the Grievance: _____ Date: _____
Please note: Clients are not required to sign this form

I have been advised of my right to ask for help in filing my grievance. I have received written information about the grievance process. _____ (please initial if correct).
I have designated the above person to act as my representative and to assist me in this grievance process. _____ (if applicable, client initials).

If applicable, please indicate the HFC staff assisting to complete this form:
Name:_____ Job Title:_____

When completed, please return this report and any additional pages to Hispanic Family Counseling Inc. OR mail to:
6900 S. Orange Blossom Trail, Suite 402
Orlando, FL 32809

Date Report Received: _____