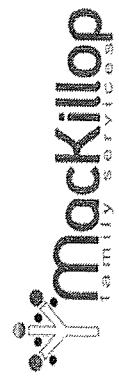


Date Complaint Received	Source of Complaint	Client Details	Nature of Complaint	Outcome Sought	Outcome Description	Date Complaint Resolved
	NAME: Phone/F2F?:	NAME: DOB: DISABILITY: STAFF MEMBER RESPONSIBLE:				



Client Feedback for the month of _____ 2009

Date Reviewed: _____

Program Manager/Coordinator Signature _____