Aging and Disability Resource Center of Jackson County

COMPLAINT FORM

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To help us ensure that we understand your complaint and can respond promptly, please complete this form and return to:

Aging and Disability Resource Center of Jackson County
Attn: Director
420 W Hwy 54
PO Box 457
Black River Falls, WI 54615

YOUR NAME: _____

NAME OF CUSTOMER:
(if you are filing a complaint on behalf of another individual)

YOUR ADDRESS: _____

_____

_____
City, State, Zip Code

YOUR PHONE NUMBER: _____

PLEASE DESCRIBE YOUR COMPLAINT:

Please be as specific as you can. Include any names or dates as this may help resolve your complaint. You can use the back of this form or attach additional information to describe your complaint. You can also ask the ADRC for help in completing this form.

_____
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Please tell us how you would like to see your complaint resolved:

Signature_____ **Date**_____