EAU CLAIRE COUNTY
DEPARTMENT OF HUMAN SERVICES

COMPLAINT SCREENING FORM

Complainant:		Telephone No:	
Street Address:			
Alternate Telephone No:			
Mailing Address (If different):			
Best Time to Call:		Can a message be left on machine? ☐ Yes ☐ No	
City:		State:	Zip:
Client (If not complainant):			
Street Address:			
Alternate Telephone No:			
Mailing Address (if different):			
Best Time to call:		Can a Message be left on machine? ☐ Yes ☐ No	
City:		State:	Zip:

SERVICES RECEIVED AT THE DEPARTMENT

☐ Economic Assistance Unit (Foodshare, Badgercare Plus/Medicaid, Child Care)
☐ Family Services Unit
☐ Behavioral Health Services Unit

Name of Social Worker: ______________________________

I am receiving services for: ______________________________

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Please briefly state your complaint: ______________________________

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Is this complaint against a specific staff person? ☐ Yes ☐ No (If yes, please name):

Relief sought: ____

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______________________________ ______________________________
Signature Date

updated 6/11/2020