Miami-Dade County Homeless Trust

GRIEVANCE COMMITTEE REQUEST FORM

Date:_____

COMPLAINANT INFORMATION

Your Name: _____
(Last) (First) (Middle Initial)

Address:_____
(Street) (Apt. #)

_____
(City) (County) (State) (Zip Code)

Telephone: (Mobile) _____

(Other) _____

COMPLAINED OF:

Name of Provider:_____

Project Name or Office Address: _____

Provider Contact Person Name: _____

Provider Contact Person Telephone: _____

Did you initiate the grievance process with the provider? (circle one): Yes or No

What was the outcome of the grievance process (circle one):

Denied Services Discharged from Program Other (please explain):

_____
_____
_____

WITNESSES

Do you have a witness? _____

If so, name of the witness:

_____

Contact information for the witness:

_____

ALLEGATIONS

Explain your complaint against the attorney in as much detail as possible. When did you retain the attorney? How much did you pay? What legal services did the attorney agree to perform for you? What did the attorney actually do for you? What conduct did the attorney commit that you believe is improper? Send this office COPIES of all documents that you believe support your claim, with the names and addresses of any witnesses. (Please use a pen with black ink. If necessary, continue your narrative on a separate sheet of paper.)

Please Sign Here

Note: Unsigned complaints will not be processed.