



Northwest Florida Continuum of Care

Bay • Calhoun • Gulf • Holmes • Jackson • Washington

Client Grievance Form

Date: _____

Client(s) Name(s): _____

Phone /Text Number: _____

E-mail Address: _____

Mailing Address: _____

How would you like to learn about the grievance decision (choose one)?

Telephone Call E-mail Mailed Letter Text

Would you like to review the reason a decision was made with a Supervisor Yes No

Name of CoC Staff Involved: _____

Do you need interpretation assistance or this document in another language? Yes No

What CoC decision do you disagree with and why?*

What do you think should have happened and why?*

*Feel free to use the back of this sheet or attach a second page.

CoC Client Signature (typed name is ok): _____ Date: _____

Please submit this form via email to FL515grievance@gmail.com. Your concerns are taken seriously and the CoC Grievance Committee will respond within 15 business days of the receipt of the completed form.

CoC Staff ONLY: Date of Receipt: Program: