



COMPLAINT/COMMENT FORM

The Milwaukee County Area Agency on Aging aims to provide you with safe, effective, and reliable services, free from discrimination, and relies on your feedback. Please complete for any Complaints/Comments you may have.

Please check the type of Complaint/Comment you are filing:						
Discrimination Based Upon:		<input type="checkbox"/> Race <input type="checkbox"/> Color <input type="checkbox"/> National Origin <input type="checkbox"/> Disability <input type="checkbox"/> Gender <input type="checkbox"/> Religion <input type="checkbox"/> Age <input type="checkbox"/> Other _____				
Failure to Provide Information in my Language:		<input type="checkbox"/> Español <input type="checkbox"/> Hmoob/Hmong <input type="checkbox"/> Other _____				
Services Performed by the Milwaukee County Area Agency on Aging:				<input type="checkbox"/>		
Services Performed by another Agency:				<input type="checkbox"/> Agency Name: _____		
Participant Name:						
Participant ID (if any):						
Street Address:						
City, State, Zip Code:						
Phone (Home/Mobile):						
Email:						
Any Accommodation You Need	<input type="checkbox"/> Large Print	<input type="checkbox"/> TDD/Relay	<input type="checkbox"/> Audio Recording	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Language Interpreter	Other:
IF you are NOT filing this Complaint/Comment on your OWN behalf, please provide your name and relationship with the person for whom you are complaining or commenting:						
Did you obtain the permission of the participant if you are filing on behalf of someone else? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Service at Issue:						
<input type="checkbox"/> Caregiver Support <input type="checkbox"/> Counseling <input type="checkbox"/> Dementia <input type="checkbox"/> Dining Site <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Info & Referral <input type="checkbox"/> Legal Services <input type="checkbox"/> Long Term Care Options <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Medicare <input type="checkbox"/> Outreach <input type="checkbox"/> Senior Center <input type="checkbox"/> Social Support <input type="checkbox"/> Transportation <input type="checkbox"/> Wellness						
When (date and time) did the Incident happen?						
Where did the Incident happen (if known)?						
Name/ID of Employee(s)/Vehicle or Others Involved:						

Description of Incident (Please detail your Complaint/Comment in your own words.)

What do you want to happen as a result of this Complaint/Comment?

Have you already complained to/complimented the vendor (if any) directly? If yes, please list date of communication.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date:	

Please describe any other steps <u>you have already taken</u> to address the conflict or problem?	
What type of corrective actions took place?	

If you have filed a similar complaint with any <u>other</u> federal, state, or local agency, or with any Federal or State Court, please list the name of the agency or court:	
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Please attach any documents you have which support your complaint.

SignatureDate

Print Your Name

Please submit this form in person, via U.S. Mail or electronically at county.milwaukee.gov/aging/about

MILWAUKEE COUNTY AREA AGENCY ON AGING
 1220 W. Vliet Street, Suite 302
 Milwaukee, WI 53205
agingcomplaint@milwaukeecountywi.gov

You may also **call us** at: **(414)289-6546**. Please provide your contact information to receive a response.