HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola
Main Office: 1707 Orlando Central Parkway, Suite 480 • Orlando, FL. 32809
(407) 382-9079 • Fax (407) 964-1274
referrals@hispafam.com • www.hispafam.com

GRIEVANCE REPORT

Client Name: _____ Date: _____

Individual filing the report:

☐ Client
☐ HFC staff on behalf of client
☐ Family Member
☐ Other client representative

Contact information (if other than Client or HFC staff):

Name: _____
Relationship to Client: _____
Address: _____
_____
Telephone: _____

- I have designated the above person to act as my representative and to assist me in this grievance process. _____ (Initial here if applicable)
- I have been advised of my right to ask for help in filing my grievance. I have received written information about the grievance process. _____ (Initial here)
- If applicable, please indicate the HFC staff who assisted in completing this form:
  Name: _____

Please provide a complete description of your grievance:

What happened? Who was involved? What date did the event occur? Where did the event occur? If more space is needed, please attach additional pages. Check box if additional pages are attached. ☐

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of person completing report: _____ Date: _____

Please note: Clients are not required to sign this form

When completed, please return this report and any additional pages to Hispanic Family Counseling, Inc.

OR mail in a sealed envelope to:
6900 S. Orange Blossom Tr., Suite 402 Orlando, FL 32809

OR fax to:
(407) 964-1274

Date Report Received: _____