**Larimer County Department of Human Services (LCDHS)**

**Complaint Form**

**Attn:** Complaint Coordinator

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| Your Name: |       | Today’s Date: |       |
| Preferred contact method: |       | Date of Birth: |       |
| Mailing Address: |       |       |       |       |
|  | Street | City | State | Zip Code |
| Telephone: |       | Email: |       |
| Provide any case number or other id number to help route your complaint: |       |
| Your role: | ☐ Subject of Investigation | ☐ Parent, Guardian, or POA of Client |
|  | ☐ Client or Applicant |  | ☐ Other: |       |

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| What type of complaint are you filing today? | ☐ Case Complaint | ☐ Civil Rights Complaint |
| If you chose Civil Rights Complaint, please select the civil right that was violated: | ☐ Age☐ Color☐ Creed☐ Disability☐ National Origin☐ Political Beliefs |  | ☐ Public Assistance Status☐ Race☐ Religion☐ Sex☐ Sexual Orientation |

Please describe your complaint, providing the names of the employee or employees involved (if known).

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What do you want the Department to do in response to the complaint?

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What have you done to resolve the issue so far?

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Please provide any additional information here if needed:

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Once you have completed this form, please email to hs-info@co.larimer.co.us, mail the form or submit it in person at any one of the Human Services locations. The Complaint Coordinator or another staff member will contact you within 2 business days of receiving this form.

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_