Welcome to the Abilities First Grievance form. This form is intended for use by Abilities First personnel, individuals served, their family members, and other stakeholders or Abilities First partners to file a formal complaint. We highly value your feedback and are dedicated to utilizing it to resolve issues and enhance our services. Please provide as much detail as possible regarding your concern. Rest assured, if you include your contact information, you will receive confirmation of receipt within 24 business hours. Our goal is to address and resolve concerns promptly and effectively, upholding our commitment to excellence.

**Contact Information**:

***Anonymous submission*** (cannot provide follow-up) [ ]

**Full name:** Click or tap here to enter text.

**Phone number**: Click or tap here to enter text.

**Email address:** Click or tap here to enter text.

**Relationship to Abilities First:** [ ]  AF Personnel [ ]  Person Served [ ]  Family Member [ ]  Stakeholder [ ]  Partner [ ]  Other (Please Describe): Click or tap here to enter text.

**Which Program or Department is the grievance related to?** [ ]  The Next Step [ ]  First Steps [ ]  Art Academy [ ]  Community Education [ ]  Steps Forward (DD Health Home [ ]  Other Reason for grievance (Please Describe):

**Date of Incident/Issue Occurrence**: Click or tap to enter a date.

**Time of Incident/Issue:** Click or tap here to enter text.

**Incident/Issue Occurrence Location**: Where did the incident/Issue occur?

 Click or tap here to enter text.

**People Involved**: Who was involved in the situation (names and roles)?

Click or tap here to enter text.

**Description of the Concern**: Please provide a very detailed description of the issue or incident.

Click or tap here to enter text.

**Impact**: How has this issue affected you or others involved?

Click or tap here to enter text.

**Desired Outcome**: What resolution or action are you seeking?

Click or tap here to enter text.

**Supporting Documentation**: Are there any documents, photos, or evidence related to your complaint? *Please send in with your report.*

Click or tap here to enter text.

**Previous Steps Taken**: Have you already reported this issue to anyone else? If so, please provide details.

**Witnesses**: Were there any witnesses to the incident? If so, please provide their names and contact information.

Click or tap here to enter text.

**Resolution History**: Have you previously discussed or attempted to resolve this issue with anyone at Abilities First including the individual (s)? If so, who and what was the outcome?

Click or tap here to enter text.

**Follow-Up Preference**: How would you prefer to be contacted regarding your complaint (e.g., phone, email)?

Click or tap here to enter text.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you want to submit this form anonymously you may skip the signature.*

**The completed form should be submitted to:**

**Vice President of Administration or the Vice President of Compliance**

 Forms may be mailed to: 3216 S. National Ave., Springfield, MO 65807