Alaska Department of Health
Division of Public Assistance

COMPLAINT FORM

Client Name:_____ Date: _____

Client Address:_____ Telephone: _____

Employee Name (if known):_____ Case Number (if known):_____

Check Program:

☐ SNAP ☐ Alaska Temporary Assistance ☐ Heating Assistance

☐ Medicaid ☐ Adult Public Assistance ☐ Interim Assistance

☐ Senior Benefits ☐ General Relief

Type of Complaint:

☐ Change processing delayed more than 10 days

☐ Rude/inconsiderate/belligerent employee: employee name: _____

☐ Delay in benefits/non-receipt of benefits

☐ Long wait to apply – Specify length of time: _____

☐ Was not informed or was misinformed

☐ Agency lost change report, application, or other form

☐ Unable to make contact with office/caseworker

☐ Other: _____

Details of Complaint

Client Signature:_____ Date:_____

Important: This complaint form will be forwarded to the regional manager for evaluation to both the extent and trends of problem areas, which may need corrective action. Completion of this form will not involve you in a hearing.