

NDBEDP Client Complaint

Applicants or participants in the National Deaf-Blind Equipment Distribution Program (NDBEDP) may use this form to submit a complaint about the program. The form must be filled out completely or it will not be accepted. Mail this completed NDBEDP Client Complaint form to ODHH at the address below, or fax to 360-902-0855.

PO BOX 45301
OLYMPIA WA 98504-5301

For help completing this form, you can contact ODHH at the numbers provided below.

(800) 422-7930 V/TTY (360) 902-8000 V/TTY (360) 902-0855 FAX	Video IP : 360-339-7382 E-mail: ndbedp@dshs.wa.gov Web : http://www.dshs.wa.gov/hrsa/odhh/ndbedp.shtml
--	--

Please type or print clearly.

1. Client Information			
NAME	TELEPHONE NUMBER	<input type="checkbox"/> Voice	<input type="checkbox"/> VP
		<input type="checkbox"/> TTY	<input type="checkbox"/> Other
ADDRESS	CITY	STATE	ZIP CODE
E-MAIL ADDRESS			
2. Type of Complaint			
<input type="checkbox"/> Application process <input type="checkbox"/> Assessment process <input type="checkbox"/> Training <input type="checkbox"/> Equipment <input type="checkbox"/> Accessibility <input type="checkbox"/> Other:			
3. Please explain your complaint below.			
CLIENT'S SIGNATURE			DATE (MM/DD/YYYY)
4. Person completing form (if other than client)			
NAME	TITLE		
SIGNATURE			DATE (MM/DD/YYYY)

For office use only

DATE (MM/DD/YYYY)

PERSON RESOLVING COMPLAINT

EXPLANATION OF RESOLUTION