艦	Markington State Department of Social & Health Services
Tran	sforming lives

## **Compliments and Concerns**

Department of Social	ompinionito ana cono	01110	DATE		
Transforming lives		CSO	DATE		
Dear Customer,					
Please share your experiences with us! We want to give you the best possible service. Let us know what we are doing right and how we can improve.					
Include the names of staff involved so that we can recognize good practices and change where we need to. Please place your completed form in the					
Your comments (use back of form, if necessary):					
☐ I would like a response to my comment. ☐ No response necessary.					
The following information is opt	ional unless you requested a r	esponse:			
YOUR NAME	CL	LIENT ID	PHONE NUMBER		
ADDRESS	Cl	TY	ZIP CODE		
DSHS COMMUNITY SERVICES					
CUSTOMER CONNECTION					

DSHS 16-243 (08/2019)

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