



## **PROGRAM PARTICIPANT GRIEVANCE PROCEDURES**

Community Action Partnership of Mid-Nebraska will not discriminate in the provision of services to an applicant because of their race, color, national origin, sex, age, religion, political affiliation, marital status, family status, or disability status.

It is our intent to provide courteous and professional services to all who meet the eligibility guidelines for the individual programs we administer.

If a program participant or applicant has a complaint about an incident or denial of services they should immediately notify the supervisor of the program involved for resolution of the problem. This information will be provided by on site staff, is available on our web site at [www.communityactionmidne.com](http://www.communityactionmidne.com), or may be obtained by calling our toll free number of 1-877-335-6422.

If the participant or applicant is not satisfied with the response or if the problem involved the program supervisor, they may send a written statement of the grievance or complete a grievance form and send it to the following address:

Grievance Committee  
Community Action Partnership of Mid-Nebraska  
16 W. 11th Street  
P.O. Box 2288  
Kearney, NE 68848

All complaints or grievances will be promptly investigated by the Grievance Committee and the resolution will reflect the program guidelines. The Executive Director, will issue a final determination for resolution of the grievance. This determination may be subject to review by the Community Action Board of Directors' Executive Committee.

**COMPLAINT**  
(Under Grievance Procedures)

A written statement of the complaint is to be completed by the aggrieved individual and sent to the following address:

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Grievance Committee.  
Community Action Partnership of Mid-Nebraska  
P.O. Box 2288  
Kearney, NE 68848

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If you need help completing this form, please call 1-877-335-6422 for assistance.

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**Today's Date :** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Date Incident Occurred or Complaint Originated:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Your Name :** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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Please complete all of the sections **that apply** to your concerns and please sign the form below. Attach any additional information that may help us to resolve your situation.

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**Please describe the type of services you were requesting:**

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**I was told that Community Action Partnership would not provide me services. I disagree with this decision because:**

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**I am unhappy with the services that I am receiving because:**

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**I am unhappy with one of your employees because:**

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Please provide or attach any additional information that may be helpful to a resolution of this situation.

Your concerns will be reviewed by the Grievance Committee within 30 days of receipt of the information. The Executive Director will issue a final determination for resolution of the grievance. This determination may be subject to review by the Community Action Board of Director's Executive Committee.

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Your signature