



Complaint Form

Date: _____

Complaint submitted to the IHSS Public Authority via:

This Complaint Form Email Written Letter/Statement Fax

Section 1. Personal Information

The Complainant is:

Individual Provider/Caregiver Consumer/Client Other

Please Print

Name of Complainant		Social Security Number (for Individual Provider only)	
Address		Email Address	
City		Zip Code	
Home Phone	Cell Phone		Other Phone

Section 2. Nature of Complaint

(to be completed by Complainant or attach written complaint)

(Explain in detail the nature of the complaint including any relevant dates, names, etc relevant to the complaint. Feel free to attach a written statement or additional pages if necessary)

Section 3. Requested Solution

(to be completed by Complainant or attach written complaint)

(Explain in detail what you are requesting as a resolution to your complaint.)

Signature of Complainant (unless complaint submitted by email or other written statement)

IHSS Public Authority Administrative staff initials complaint submitted by email or other written statement): _____

Please return this complaint form to the Public Authority by the following methods:

- Lobby: In-person or dropbox
- Telephone: (866) 351-7722
- Fax: (858) 224-0254
- Website: <https://www.sdihsspa.com/contact/>
- Mail: Public Authority
Attn: Admin. Department
401 Mile of Cars Way, Suite 200,
National City, CA, 91950

