AIDS Drug Assistance Program (ADAP) Client Grievance Form

Name: _____ Date of Birth: _____

What is the complaint?

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What would you like to happen?

_____

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_____

Client signature: _____

Date: _____

Please fax the completed form to (804) 864-8050 or mail to:

Virginia Department of Health
HCS Unit, 1st Floor
James Madison Building
109 Governor Street
Richmond, VA 23219