



Mississippi Department of Health

COMPLAINT FORM UNDER PART C  
OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT 2004 AMENDMENTS

Please indicate your efforts to work out the situation:

YES

NO

I have talked with the Service Coordination and/or District Coordinator about this issue. If yes, please indicate with whom and when.

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YES

NO

I have met with other health district personnel and/or my provider(s) about this issue. If yes, please indicate with whom and when?

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YES

NO

I have been a part of an IFSP team meeting to discuss this situation. If yes, when? What was the result? Who were members of the team?

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YES

NO

This alleged violation occurred not more than two (2) years prior to the date the complaint was received by the Mississippi Department of Health.

If the alleged violation occurred more than two (2) years prior to the date that the complaint was received by the Mississippi Department of Health, respond to the following two statements.

I believe a longer period of time is reasonable because I believe the violation is continuing.  
OR

I am seeking compensatory services for a violation that occurred not more than three (3) years prior to the date the complaint was received.

Person Filing Complaint

Are you the child's legal guardian?

Relationship to Child

YES  NO

Signature of Person Filing Complaint

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Address

Name of Organization, if Applicable

Telephone Number or Other Method of Contact

Send completed form to: Mississippi Department of Health  
First Steps Early Intervention Program  
570 E. Woodrow Wilson  
Jackson, MS 39215