HEALTH CARE
AUTHORITY

If you think a health care entity may have violated the law relating to your care, or the care of someone you know, please provide as much detail as possible on the complaint form below. When completing the form, please include as much information as possible. Incomplete information may result in our inability to take action. Please understand that not all concerns may be actual violations of the law. In general, incidents older than twelve months do not result in an on-site investigation, though the information is retained in our file. After we have reviewed your information, we will send you an e-mail response explaining the disposition of your complaint.

You may wish to remain anonymous but if you do not provide the necessary contact information, we will not be able to contact you further regarding the complaint. If you wish to know the results of the investigation, please include your name, address, and contact information on the complaint form under the Complainant Information section below. You may skip this section if you wish to remain completely anonymous, but the SA will not be permitted to provide any follow up on the outcome of the complaint and will not be able to contact you for additional information should that be necessary.

Consumer Complaint Form

Complainant Information		
Your Name:		
Mailing Address:		
City:	**State:**	**Zip Code:**
Primary Phone:	**Secondary Phone:**	**Email:**
Relationship to the patient/resident: **self ____ spouse____ child____ parent____ sibling ____ friend____ caregiver ____** **other: ____ (If other, please specify): ____**		
Are you the Healthcare Power of Attorney for the patient/resident? Yes____ No____ **If NO, has the patient/resident authorized you to receive information concerning their care? Yes____ No____** **(If yes, please provide documentation of that authorization.)**		
Do you wish to remain anonymous? Yes____ No____		
Healthcare Entity Information		
Healthcare Entity Name:		
Mailing Address:		
City:	**State:**	**Zip Code:**
Phone:		
Patient/Resident Information		
Patient/Resident Name:		
Date of Birth:	**Age:**	**Sex:**
Date of admission to the healthcare entity (if known): _______________ **Is the patient/resident still receiving services from the healthcare entity? Yes ____ No ____** **Floor #: _____ Room #: _________** **If NO, date of discharge from the entity (if known): ______________**		

Discharged to: home____ hospital____ different facility ____ deceased____ other____________

Is the resident able to answer questions if contacted by our staff? Yes____ No____

If YES, please provide the best way to contact the resident: ________________________________

____

Details of the Complaint

What are your concerns? Please select all that apply:

- Care not being provided
- Inadequate care
- Cleanliness of facility
- Unsafe conditions
- Quality of the food
- Abuse
- Neglect
- Exploitation
- Roommate conflicts
- Room temperature
- Lost/stolen items
- Noise level
- Untrained staff
- Poor service from staff
- Insufficient staff
- Lack of activities/social stimulation
- Lack of observation
- Inappropriate release of confidential information
- Other

Please provide a narrative of the details of the concern(s) selected above and be as specific as possible. If necessary, additional information and/or supporting documentation may be attached to this form.

Where did this occur? Please select all that apply:

- Resident/Patient room
- Dayroom
- Bathroom
- Dining Hall
- Entrance/exit to building
- Hallway
- Stairwell
- Kitchen
- Patio
- Facility grounds
- Other (Please explain): _____________________________

When did this occur? Please provide date(s)/time(s) (if known):

Has this concern occurred before? Yes: _______ No: ________

If so, when:____

Who was involved? Please include individuals directly involved and those that witnessed the incident/concern. (Check all that apply):

Staff: _____ Resident(s): _____ Visitor(s): _____ Family:_____ Other:_____

Please list their first and last name, contact information, and their relation to the resident (if known):

Complaint Information

Were your concerns reported to the facility? Yes_____ No_____

If so, who was it reported to? ______________________________

When was this reported? __________________________________

What was the facility's response? ____

Were your concerns addressed by the facility staff? Yes____ No____ **If YES, what did the facility staff do to address your concerns?**
If NO, describe how the facility staff did not address your concerns. Please include a description of the expected resolution.
Did you report your concerns to Law Enforcement? Yes____ No____ **If yes, who was it reported to? __________________________** **When was it reported? _______________________** **Please provide the case number (if known): ____________________________** **What was their response? ____** **____**