|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date Received: | | Time received:       (*24 hour*) | | | Received By: | | | Method of Contact: | | |
| **COMPLAINANT INFORMATION** | | | | | | | | | | |
| Anonymity Requested | | | | | | | | | | |
| Complainant Name: Last: | | | First: | | Complainant County: | | | | | |
| Complainant Relationship: | | | | | Complainant Phone: | | | | | |
| Consumer name (if not complainant) Last: | | | | | First: | | | | | |
| Consumer Age Group | | | | | | | | | | |
| **NATURE OF COMPLAINT/CATEGORY** | | | | | | | | | | |
| Ombuds Notified: YES  NO | | | | | | Date of the Event: | | | | |
| Brief description of the Complaint: | | | | | | | | | | |
| ALLEGATION1: | ALLEGATION2: | | | | | ALLEGATION3: | | | ALLEGATION4: | |
| ALLEGATION5: | ALLEGATION6: | | | | | ALLEGATION7: | | | ALLEGATION8: | |
| Directed At: | | | | | | Provider Agency: | | | | |
| Priority Level: | | | | | DSHS Constitute Relations? YES NO | | | | | |
|  | | | | | Status: | | | | |
| **Follow up action taken:** | | | | | | | | | | |
| **RESOLUTION** | | | | | | | | | | |
| Entities Notified/Referred | | | | | | | | | | |
| Law enforcement notified  Regional Administrator  APS notified  CPS notified | | | | Medicaid Control Fraud Unit  Department of Health  Agency grievance process  US Attorney (42 CFR) | | | Regional Support Network  None  Other:  **Date of referral:** | | | |
| Consent form needed?  YES  NO | | | | | Date Consent form sent: | | | | | |
| Investigated?  YES  NO | | | | | Investigative Actions Taken: | | | | | |
| ALLEGATION1: | ALLEGATION2: | | | | | ALLEGATION3: | | | ALLEGATION4: | |
| ALLEGATION5: | ALLEGATION6: | | | | | ALLEGATION7: | | | ALLEGATION8: | |
| Resolved?  YES  NO | | | | | Date CLOSED | | | | | |