

COMPLAINT REPORT

*This form is intended to document complaints received in the licensing office. **Unless the complaint is considered harassment, a licensing visit must be conducted within 10 calendar days after receipt of the complaint.***

REPORT			<input type="checkbox"/> URGENT <input type="checkbox"/> PRIORITY NO. _____ <input type="checkbox"/> RIS REFERRAL		
REPORTED <input type="checkbox"/> IN PERSON <input type="checkbox"/> BY LETTER <input type="checkbox"/> BY TELEPHONE			DISTRICT OFFICE	VISIT DUE DATE	CONTROL NUMBER
COMPLAINANT NAME			FACILITY INFORMATION		
ADDRESS STREET		CITY	TYPE OF FACILITY		FACILITY FILE NUMBER
TELEPHONE NUMBER (DAY) AREA CODE ()		TELEPHONE NUMBER (EVENING) AREA CODE ()	FACILITY NAME		
RELATIONSHIP/INVOLVEMENT WITH FACILITY			ADDRESS	STREET	
WAS ABUSE REPORT REQUIRED AND FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO			CITY	ZIP CODE	
DOES COMPLAINANT WISH TO REMAIN ANONYMOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO			TELEPHONE NUMBER	AREA CODE ()	

NATURE OF COMPLAINT (*Separate complaint into specific allegations and assign one of the following complaint codes:*)

- | | | | | |
|---------------------------------------|-------------------|---------------------------------|---------------------|------------------------|
| 1. Physical Abuse/Corporal Punishment | 5. Fire Clearance | 9. License | 13. Medication | 17. Financial Issues |
| 2. Sexual Abuse | 6. Crimes | 10. Neglect/Lack of Supervision | 14. Financial Abuse | 18. Questionable Death |
| 3. Personal Rights | 7. Physical Plant | 11. Food Service | 15. Level of Care | 19. Other |
| 4. Unlicensed Care | 8. Record Keeping | 12. False Statements | 16. Qualifications | |

COMPLAINT CODE	ALLEGATIONS	RESOLUTION CODE		
		S	I	U

RECEIVED BY ▶	DATE	TIME
------------------	------	------

DETAILS OF ALLEGATION(S)/DESCRIPTION OF INCIDENT(S)

PRE-INVESTIGATION CONTACT WITH COMPLAINANT	POST-INVESTIGATION CONTACT WITH COMPLAINANT
DATE CONTACTED	DATE CONTACTED
PERSON CONTACTED	PERSON CONTACTED
HOW CONTACTED <input type="checkbox"/> TELEPHONE <input type="checkbox"/> LETTER <input type="checkbox"/> IN PERSON	HOW CONTACTED <input type="checkbox"/> TELEPHONE <input type="checkbox"/> LETTER <input type="checkbox"/> IN PERSON
COMMENTS	COMMENTS
_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____

SUMMARY OF OTHER CONTACTS/REPORTS

FOLLOW-UP/COMMENTS:

LICENSING EVALUATOR'S SIGNATURE	DATE	LICENSING SUPERVISOR'S SIGNATURE	DATE
▶		▶	