

Facility Name: _____

Must use a separate sheet for each facility

Date received: _____

Complaint Code: _____

Complainant Types (Circle one)

- A Resident
- B Relative/Friend
- C Non-relative Guardian/Legal Representative
- D Ombudsman
- E Facility
- F AAA Info & Assistance
- G Other Social Service Agency
- H Other Medical: Physician/Staff of Hospitals, Hospices, clinics, etc.
- J Unknown/Anonymous
- K Other

Complaint/Concern: _____

Action taken: _____

Ombudsman Name: _____

Date received: _____

Complaint Code: _____

Complainant Types (Circle one)

- A Resident
- B Relative/Friend
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Complaint/Concern: _____

Action taken: _____

<p>Status Types (circle one)</p> <p>Z Regulatory/Legislative Action</p> <p>Y Not Resolved</p> <p>X Withdrawn</p> <p>W Referred to another agency</p> <p>V No action needed or appropriate</p> <p>U Partially resolved</p> <p>T Resolved</p>	<p>Action Agency (circle one)</p> <p>a Certified Ombudsman</p> <p>b TDoA</p> <p>c TDHS</p> <p>d TDPRS</p> <p>e Other</p>	<p>Status Types (circle one)</p> <p>Z Regulatory/Legislative Action</p> <p>Y Not Resolved</p> <p>X Withdrawn</p> <p>W Referred to another agency</p> <p>V No action needed or appropriate</p> <p>U Partially resolved</p> <p>T Resolved</p>	<p>Action Agency (circle one)</p> <p>a Certified Ombudsman</p> <p>b TDoA</p> <p>c TDHS</p> <p>d TDPRS</p> <p>e Other</p>
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