

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:

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X Withdrawn	c TDHS	X Withdrawn	c TDHS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