Must save to your computer to use Submit Feature.

RESET

LONG-TERM CARE OMBUDSMAN COMPLAINT DOCUMENTATION

Ombudsman	Intake Date

First Action Date	Close Date

INTAKE SUMMARY

Anonymity Requested?	Consent Obtained to Work on Resident's Behalf	Consent to Review Records
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No If yes, ☐ oral or ☐ written

COMPLAINANT

Complainant Role	Complainant Name

Agency/Company	Address

Home Area Code and Telephone No.	Work Area Code and Telephone No.	Cell Area Code and Telephone No.

FACILITY

Type	Name
☐ SNF/ICF ☐ RCF/ALF	

RESIDENT

Resident Name

Legally Authorized Representative?	If Yes, Name
☐ Yes ☐ No	

COMPLAINTS	VERIFIED	DISPOSITION
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	

ACTIONS

1.
2.
3.
4.

SUBMIT

Instructions

Ombudsman: Name of the Volunteer Ombudsman.
Intake Date: Date the Ombudsman Program was made aware of the complaint.
First Action Date: Date the Ombudsman completed the first case action, i.e. investigation, interviews.
Close Date: Date the complaint was closed.

Intake Summary: Summary of the initial contact regarding the complaint.
Anonymity Requested: Check "Yes" if the resident/resident representative requests the resident be anonymous. Or check "No" if the resident/resident representative gives permission to disclose the resident's identity.
Consent Obtained to Work on the Resident's Behalf: Check "Yes" if the resident/resident representative gives permission for the Ombudsman to work on the complaint on the Resident's behalf. Or check "No" if the resident/resident representative does not give permission for the Ombudsman to work on the complaint on the Resident's behalf.
Consent to Review Records: Check "Yes" if the resident/resident representative gives permission for the Ombudsman to review records. If yes, was the consent given orally or by written consent and check the appropriate box.

Complainant Role: resident, resident representative, family, etc.
Complainant Name: Name of the individual providing the complaint information.
Agency/Company: If the Complainant works for an agency/company, list the name of the agency/company.
Address: Address of the Complainant.
Home Area Code and Telephone No.: List the home telephone number for the complainant including area code.
Work Area Code and Telephone No.: List the work telephone number for the complainant including area code.
Cell Area Code and Telephone No.: List the cellular telephone number for the complainant including area code.

Facility
Type: Check the appropriate box for either Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) or the box for Residential Care Facility/Assisted Living Facility (RCF/ALF).
Name: List the name of the facility the resident resides.

Resident
Resident Name: List the name of the resident
Legally Authorized Representative: Check 'Yes" if the resident has a legally authorized representative. Check "No" if the resident does not have a legally authorized representative.
If Yes, Name: List the name of the legally authorized representative.

Complaints: List the complaints
Verified: Check "Yes" if after investigation it is determined that the circumstances described are generally accurate. Check "No" if after investigation, you are unable to confirm most circumstances alleged by the complainant are likely to be accurate.
Disposition Codes: List the corresponding letter.

a. Legislative or Regulatory Action Required
b. Not Resolved
c. Withdrawn
d.1 Referred for Resolution/Final Disposition Not Obtained
d.2 Referred for Resolution/Other Agency Failed to Act
d.3 Referred for Resolution/Agency Did Not Substantiate
e. No Action Needed or Appropriate
f. Partially Resolved
g. Resolved

Actions: List the action for complaint 1 on Action line 1 and continue if multiple complaints. If more space needed, add another sheet of paper.