

New York State Long Term Care Ombudsman Program
Complaint Form



Ombudsman Name:

Facility Name:

Date Received:

1) Name of complainant (if not resident):

2) Complainant Role (select **one**):

- | | |
|--|---|
| <input type="checkbox"/> Ombudsman | <input type="checkbox"/> Resident |
| <input type="checkbox"/> Facility administrator/Staff | <input type="checkbox"/> Relative or friend of resident |
| <input type="checkbox"/> Guardian/legal representative
(non-relative) | <input type="checkbox"/> Social service agency/program |
| <input type="checkbox"/> Medical: physician or staff | <input type="checkbox"/> Other : |
| | <input type="checkbox"/> Unknown/Anonymous |

3) Resident name:

4) First Action Date (date investigation began):

5) Date Case Closed:

6) Permission to reveal identity of resident and or complainant: YES NO
Date of Permission:

Waiver YES NO Please attach.

7) Complaint Description: Identify allegations. Include details (date, time, location, witnesses) of each allegation/issue to be investigated.

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8) Investigation Notes/ Journal of Events: (Include observations, interviews and supporting documentation as appropriate. Be sure to document dates, time, of investigation.)

9) Resolution (provide a description of how each complaint was resolved; include details and time frames as appropriate):

Findings:

10) Complaint Code	11) Verified (Y or N)	12) Disposition	Disposition Codes
	<input type="checkbox"/> Y <input type="checkbox"/> N		A. Government policy, regulatory change or legislative action required B. Not resolved to satisfaction of resident/complainant/ombudsman C. Withdrawn by resident or complainant D. Referred to other agency for resolution 1. Final disposition was not obtained 2. Agency failed to act on complaint 3. Agency did not substantiate complaint E. No action needed or appropriate F. Partially resolved, but some problem remained G. Resolved to the satisfaction of the resident/complainant/ombudsman
	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> Y <input type="checkbox"/> N		

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