MARKS HOME CARE

Complaint Investigation Report

SECTION 1. INFORMATION ABOUT THE COMPLAINANT

Individuals filing a complaint are not required to answer questions on this Section. However, the Agency may not be able to contact, obtain additional information or reach the involved parties to notify them of the results of the investigation.

Name:

Address:

City:	State:	Zip Code:
Primary Phone	Secondary Phone	Best time to contact you ☐ AM ☐ PM

Date you filed the complaint: ___/___/____

SECTION 2. PATIENT INFORMATION

Patient ID#	Date of Birth: ___/___/____

Your Relationship to the Patient:

☐ Patient (self) ☐ Family Member (Spouse/Child/Parent) ☐ Friend ☐ Present or former Agency employee
☐ Legal representative/guardian/power of attorney ☐ Law Enforcement Agency ☐ Patient's Insurance Company
☐ City/State Dept. of Health ☐ Media ☐ Anonymous Other, please explain: _____

Is the Patient still receiving services at the Agency? ☐ No ☐ Yes ☐ Do not know

Please provide as much information as possible including the date, time, how often the concern has occurred, and the location where the concern occurred. Complainant may use examples.

_____
_____
_____
_____
_____
_____

Names of any other person(s) or witness(es) involved in this complaint:

Name: _____ Contact Info (if known): _____

Name: _____ Contact Info (if known): _____

SECTION 3. REPORTING OF COMPLAINT

Did you report this complaint to the Agency?
☐ No ☐ Yes If yes, please complete the items below:
A. Date the complaint was reported to the Agency:
_____/_____/____
B. Name and title of the Agency employee to whom the complaint was reported:
Name: _____ Title: _____

SECTION 4. COMPLAINT RESOLUTION

What do you think should happen in this situation?

_____
_____
_____
_____
_____