DD COMPLAINT FORM

Name of Individual(s) involved in the complaint:	Date of Occurrence:	Time of Occurrence:

Specific Location related to this report if different from above:

Provider owned property ☐ Non-Provider Owned Property ☐ Other ☐

Physical Address: _____ Apt. Room/or Bldg #: _____

Town/City: _____ County _____ Zip Code _____

Complainant's Name/Title: _____Phone #_____

This form was completed by: _____ Phone #_____

May we contact you regarding this complaint? Yes ☐ No ☐

What occurred that resulted in your complaint today:

_____

_____

_____

_____

Have you talked to the provider about this? Yes ☐ No ☐ If yes, please describe below.

_____

Additional Comments/Details:

_____

If there were others who witnessed the incident, please provide:

Names of All Witnesses (Please Print)**:**

Staff	Individuals	Other persons

DDD Central Office Use Only:

Report Received by:	***Date Received:***	***Time Received:***

DDD Central Office Use Only:

Please fax completed form to: (402) 471-8792, or email to: *DHHS.DDCBSQI@nebraska.gov*