Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

Complaint Form

Send to: DHHS.DDCBSQI@nebraska.gov

Complaint information

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 #

City	County	Zip

Complainant's Name/Title	Phone Number

This form was completed by	Phone Number

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? If yes, please describe below.

☐ Yes ☐ No

Additional Comments/Details:

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

Staff	Individuals	Other Persons

DDD Central Office Use Only

Report Received by	Date Received	Time Received

DDD Central Office Use Only: