The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Facility Licensure & Certification
Intake Unit
99 Chauncy Street, Boston, MA 02111
Fax 617-753-8165

Consumer / Resident / Patient Complaint Form

Please answer all questions on both pages as fully and clearly as possible:

1. I have notified a manager at the facility about my concerns **YES**_____ **NO**_____
2. Name of person contacted _____

Today's Date:	**Date of Event:**	**Time of event:**
Full name of Facility:	**Full Address of Facility:**	**Facility Telephone Number** (if known)
Name and address of person reporting:	**Best telephone number for contacting you:**	**Best time of day to contact you:**
Name of Resident/Patient: **Date of Birth/Age:** **Location of Resident/Patient:** **Is the Resident/Patient still at the facility? YES NO**	**I am**: (please check) Family member _____ Legal guardian _____ Power of Attorney _____ Resident/patient _____ Employee/Former Employee _____ (please indicate which) Friend _____ Visitor _____ Anonymous* _____ ***Please note if you wish to remain anonymous we will not be able to inform you of the outcome of your complaint.**	**I am not** the patient/resident and have submitted the necessary HIPAA release form to obtain details of the outcome of any investigation. **YES NO**

Please describe the event you are reporting as fully as possible including dates, names and times if you have them: (Please note additional information may be requested if necessary.)

Thank you for completing and submitting this form to DPH. You will receive an acknowledgement letter that confirms our receipt of your complaint.