Complaint Form

Office of Health Facility Complaints (OHFC)

P.O. Box 64970
St. Paul, MN 55164-0970

(651) 201-4201, 1-800-369-7994
Fax- (651) 281-9796, **TDD-** (651) 201-5797

To assist you with your complaint, the MN Department of Health requests that you complete this form and return it to this office. The information you provide may be used in an effort to resolve the problem, to request additional information or to prompt an on-site investigation. OHFC must prioritize complaints that are received, and therefore is not able to investigate every complaint. We investigate complaints relating to quality of life and quality of care at health care facilities/agencies including resident rights' concerns. We are unable to investigate billing or insurance concerns. Your complaint will be reviewed and you will be notified of our course of action. Regardless of the outcome of your complaint, information you provide will be placed in the facility's file in OHFC.

Please print clearly, using black ink

Your name:____

Address_______________________________________ Home Phone# (   )_____________

City__________________ State______ Zip________ Work Phone# (   )_____________

E-Mail Address: ____

☐ Please check this box if it is acceptable to you for this office to communicate with you via e-mail

Complaint is on behalf of:____________________________ or ☐ Yourself
(Patient/Resident/Client Name)

Patient/Resident Date of Birth___________________ Gender M / F (circle one)

Relationship to Patient/Resident (Ex: spouse, sibling, child, friend, etc.)_______________

Facility involved in you complaint: (Hospitals, Nursing Homes, Home Care Agencies, Assisted Living Facilities, ICF/MR, SLF)

Name of Facility/Agency____

Address____

What part of the facility concerns you? (name of unit, floor or location, if applicable)___________

The room Number/Unit of the resident or patient, if known or applicable______________

The date that the identified incident occurred (please include year)_______________

Do you know what type of license the facility holds? (i.e. hospital, nursing home, home care agency, ICFMR)____

What would you like to see happen to resolve this complaint?

Have you contacted the facility or agency or any other agency to help resolve this complaint? What Agency?

Did the facility or agency take any corrective action?

If your concern involves home care, please provide a copy of the clients home care contract, if possible.

TENNESSEN WARNING
The information you provide on this form may be used in an investigative report, however your identity is confidential and is not revealed to the general public, except as required by law.

Some information may be private data and may be made available only to other state and/or federal agencies, law enforcement, the Attorney General's Office, health licensing boards, the Nurse Aid Registry and/or the Minnesota Department of Human Services. If is possible that your identity might be revealed to persons participating in a hearing if a determination should result in a hearing.

The information I have given is true and accurate to the best of my knowledge and may be used as stated in this form.

Signature **Date**

Narrative Description of Complaint: (Please provide as much detail as possible, including names, dates, location and injury sustained, if any)

Attach additional sheets as necessary.