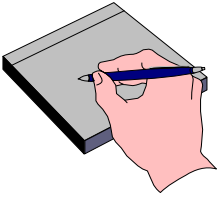


If you need assistance with completing this form:



➤ *Contact the Ombudsman Program:*

(916) 875-2000

Department of Health & Human Services
Ombudsman Program

Department of Health & Human Services
Ombudsman Program
7001 A East Parkway, Suite 1000
Sacramento, CA 95823

34 cent
Stamp
required

Department of
Health & Human
Services

Ombudsman Program



Formal
Complaint
Form

FORMAL COMPLAINT

Note: Your current services will NOT be adversely affected in any way by filing a complaint.
If you have a Formal Complaint, please complete this form, seal, stamp, and mail.

Please print or write legibly. Be specific.

Date: _____ Service Program: _____

Your Name: _____

Name of Child / Adult Complaint is about: _____

Your Relationship to Child / Adult: _____

Address (City / State / Zip): _____

Phone Number:
(Please include best time to call) _____

1. Describe the reason(s) for requesting a Formal Complaint. Please be specific by including names, dates, and times, whenever possible:

Name of Staff Person: _____

Date(s) of incident: _____

Describe Complaint or Nature of Complaint: _____

2. Have you tried to resolve the problem(s) before requesting the Formal Complaint?

Yes Please describe what you have done to try to resolve the problem and include the results.

No I have not made any prior attempt(s) to resolve the complaint.

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

Today's date: _____

Your signature: _____
