

Ohio Board of Executives for Long-term Services & Supports

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COMPLAINT FORM

COMPLAINANT: _____
(May Choose to Remain Anonymous)

Contact Method: _____

NAME & ADDRESS OF PERSON SUBJECT TO THE COMPLAINT:

NAME _____
NURSING HOME _____
FACILITY ADDRESS _____
CITY, ZIP _____

DOES THIS COMPLAINT DIRECTLY INVOLVE A NUSING HOME ADMINISTRATOR?
_____ YES _____ NO

PLEASE EXPLAIN IN DETAIL THE NATURE OF THE COMPLAINT, INCLUDE NAMES OF PERSONS WHO MAY HAVE WITNESSED THE ALLEGED ACT, DATE AND TIME OF THE ALLEGED ACT, AND ALL PERTINENT INFORMATION PERTAINING TO YOUR ALLEGATION. IF THE BOARD FINDS CREDIBLE EVIDENCE TO PROCEED WITH YOUR COMPLAINT, ALL RELEVANT PARTIES WILL BE NOTIFIED. (Attach additional pages if necessary).

Complainants Signature

Date

*THE BOARD RESERVES THE RIGHT TO REQUEST FURTHER INFORMATON IF NEEDED TO SATISFY THE COMPLAINT UNDER RELEVANT STATE LAW.