## **Long Term Care Referral Agent Complaint Form**



Purpose of form: To submit concerns about the Long-Term Care Referral Services process. Long Term Care Referral Services Oregon Administrative Rules (OARs) are online here: <a href="http://www.dhs.state.or.us/policy/spd/rules/411\_058.pdf">http://www.dhs.state.or.us/policy/spd/rules/411\_058.pdf</a>

Complaint Informati	on:				
Today's date:	Time:	a.m.	p.m.		
Long Term Care Refe	rral (LTCR) agent i	business nai	me and	the name of individua	al
LTCR agent:					
Address:			Ci	ty: ZII	code:
Phone number:	Email & website:				
<b>Description of complete documentation/informations, etc.):</b>				•	ies), alleged
Date you (complainan  Details:	nt) became aware o	of the circum	nstance	s:	date unknowr
Is the situation ongoin	g? Yes - If yes	, describe b	elow	No	
Did anyone witness th	e complaint circum	stances?	Yes -	If yes, describe below	w No
Witness Name: Email address: Witness relationship to	o complaint circum	stances:		Phone:	

Additional comments:		
Printed name and title of pers	son completing this report:	
Signature:	Title:	Date:
	tting. Click on the submit butto	nplaint form. Save a copy of the on below to send the completed
<b>G</b>	SUBMIT	