



Mark Parkinson, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

www.kdheks.gov

Division of Health

CP # _____

HOME HEALTH AGENCY COMPLAINT INVESTIGATION REPORT FORM

(Please attach additional sheets as needed.)

REPORTING AGENCY	
Name: _____	Phone No.: _____
Address: _____ (Street/PO Box) (City) (State) (Zip)	E-mail address: _____
REPORTING PARTY	
Name: _____ (Last) (First) (Middle Initial) (Title/Position)	
Address: _____ (Street/PO Box) (City) (State) (Zip)	E-mail address: _____
Telephone: _____ (Work)	_____ (Home)
INCIDENT INFORMATION	
Date of Incident (on or about): _____	
Information upon which this report is being made is as follows: (Please include a specific description of the incident, including the date, time, and location of the alleged incident.)	

Name & Cognitive Status of Resident(s)/Patient(s) involved:

If injured, please describe:

Corrective Actions Taken by the Agency:

Report made to law enforcement? Yes No

Name and address of law enforcement contact

Police Case # _____

Attachments:

- Agency Investigative Report & supportive documentation.
- Nurse Aide Registry Verification if the alleged Perpetrator is a CAN &/or CMA
- List of witnesses and **Notarized** Witness statements from those individuals regarding abuse, neglect or exploitation by an agency staff member.
- Completed Alleged Perpetrator Information Form (if applicable)

Attestation Statement: I certify that all the information given is true and correct.

Signature Printed Name Title Date

Please mail to:

**State Survey Manager
Kansas Dept of Health & Environment
Bureau of Child Care & Health Facilities
1000 SW Jackson, Ste 200
Topeka, KS 66612-1365**

State Survey Manager Use Only: Review of information has been completed. On-site survey: Yes No

Signature Date

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY OR AGENCY				
Agency: _____				
City: _____				
ALLEGED PERPETRATOR INFORMATION:				
Name: _____				
Last	First	MI	Other	
Address: _____				
Street/Box	City	State	Zip	
Telephone #: _____		Social Security #: _____		
Date of Hire: _____				
AP Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ AP Terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____				
CREDENTIALING/LICENSURE INFORMATION				
Certificate or License #: _____ (Attach copy of certificate/license)				
Type of Certification (check those that apply) <input type="checkbox"/> NAT <input type="checkbox"/> CNA <input type="checkbox"/> CMA <input type="checkbox"/> HHA <input type="checkbox"/> AD <input type="checkbox"/> SSD <input type="checkbox"/> QMRP				
Other: _____				
NAT = Nurse Aide Trainee I or II CNA = Certified Nurse Aide CMA = Certified Medication Aide HHA = Home Health Aide AD = Activities Director SSD = Social Services Designee QMRP = Qualified Mental Retardation Professional				
OR				
Type of License (check those that apply): <input type="checkbox"/> ACHA <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> OT <input type="checkbox"/> LMHT <input type="checkbox"/> LSW <input type="checkbox"/> RPT				
Other: _____				
ACHA = Adult Care Home Administrator RN = Registered Nurse LPN = Licensed Practical Nurse RPT = Registered Physical Therapist OT = Occupational therapist LMHT = Licensed Mental Health Technician LSW = Licensed Social Worker				
THIS SECTION TO BE COMPLETED BY THE STATE SURVEY MANAGER				
Case #: _____ Code #: _____ Type: _____				
The above-named perpetrator has been found to have:				
State Survey Manager Signature: _____ Date: _____				

Form CP 101 (revised 09/10)