



KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT

KATHLEEN SEBELIUS, GOVERNOR

Roderick L. Bremby, Secretary

CP No _____

HOME HEALTH AGENCY COMPLAINT INVESTIGATION REPORT FORM

(Please attach additional sheets as needed.)

REPORTING AGENCY

Name: _____ Phone No.: _____

Address: _____ E-mail address: _____
(Street/PO Box) (City) (State) (Zip Code)

REPORTING PARTY

Name: _____
(Last) (First) (Middle initial) (Title/position)

Address: _____
(Street/PO Box) (City) (State) (Zip Code)

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 Client(s) involved:

If injured, please describe:

Corrective Actions Taken by the Agency:

Report made to law enforcement? Yes No

Police Case # _____

Name and address of law enforcement contact

Attachments:

- Agency Investigative Report & supportive documentation.
- Nurse Aide Registry Verification if the alleged Perpetrator is a CNA &/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 return completed form to: **Mary Kabriel, RN, State Survey Manager,
KDHE, Bureau of Child Care and Health Facilities, 1000 SW Jackson, Suite 200, Topeka, KS. 66612-1365**

State Survey Manager Use Only: Review of information has been completed.

Onsite survey: Yes No

Signature

Date

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY	
Facility: _____	
City: _____	
ALLEGED PERPETRATOR INFORMATION:	
Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Last First MI Alias </div>	
Address: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Street/Box City State Zip Code </div>	
Telephone Number: () _____	Soc. Security _____
Date of Hire: _____	
AP Suspended? YES NO Date: _____ AP Terminated? YES NO Date: _____	
CREDENTIALING/LICENSURE INFORMATION	
Certificate or License No. _____ (Attach copy of certificate/license)	
Type of Certification (check all that apply) NAT CNA CMA HHA AD SSD QMRP Other _____	
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> NAT = Nurse Aide Trainee I or II HHA = Home Health Aide QMRP = Qualified Mental Retardation Professional </div> <div style="width: 30%;"> CNA = Certified Nurse Aide AD = Activities Director </div> <div style="width: 30%;"> CMA = Certified Medication Aide SSD = Social Service Designee </div> </div>	
OR	
Type of License (Check all that apply):	
ACHA RN LPN RPT OT LMHT LSW Other: _____	
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> ACHA = Adult Care Home Administrator RPT = Registered Physical Therapist LMHT = Licensed Mental Health Technician </div> <div style="width: 30%;"> RN = Registered Nurse OT = Occupational Therapist LSW = Licensed Social Worker </div> <div style="width: 30%;"> LPN = Licensed Practical Nurse </div> </div>	
THIS SECTION FOR OFFCIE USE ONLY:	
Case No: _____ Code : _____	
The above-named perpetrator has been found to have:	
State Survey Manager Signature: _____	Date: _____