



Susan Mosier, MD, Acting Secretary

Department of Health & Environment

Sam Brownback, Governor

CP # _____

HEALTH FACILITY/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 & <u>Cognitive Status</u> of Resident(s)/Patient(s) involved:					
If injured, please describe:					
Witness(es) to the incident were:					
Please note: <u>Witness statements regarding abuse, neglect, or exploitation by a health facility staff member need to be notarized.</u>			<u>Notarized Written Statement Attached (X)</u>		
Name Position/Relationship	Address	Telephone			
			<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 2px;">Yes</td> <td style="padding: 2px;">No</td> </tr> </table>	Yes	No
Yes	No				
			<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 30px; height: 30px; text-align: center;"><input type="checkbox"/></td> <td style="width: 30px; height: 30px; text-align: center;"><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>				
Corrective Actions Taken by Facility/Agency:					
Report made to law enforcement? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and address of law enforcement contact			
Police Case # _____					
Incident Substantiated by the Facility/Agency <input type="checkbox"/> Yes <input type="checkbox"/> No					
Facility/Agency Investigative Report/Documentation Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Attestation Statement: I certify that all the information given is true and correct.					
Name	Title	Date			
Regional Managers: Review of information has been completed. Onsite survey: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name			Date		
If the alleged perpetrator is a CNA or CMA, please attach nurse aide registry verification.					

Please mail to: **Health Facilities Program Director**
Kansas Dept. of Health & Environment
Bureau of Community Health Systems
1000 SW Jackson, Suite 330
Topeka, KS 66612

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: _____				