Bureau of Community Health Systems
1000 SW Jackson, Suite 330
Topeka, KS 66612

Phone: 785-296-1200
Fax: 785-291-3419
www.kdheks.gov/bhfr/index.html

Kansas
Robert Moser, MD, 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: _____ E-mail address: _____
(Street/PO Box) (City/State) (Zip)

REPORTING PARTY

Name: _____
(Last) (First) (Middle Initial) (Title/Position)

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

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:
Witness(es) to the incident were:
Please note: Witness statements regarding abuse, neglect, or exploitation by a health facility staff member need to be notarized. **Notarized Written Statement Attached (X)** Name Address Telephone Position/Relationship

Yes	No
☐	☐

Corrective Actions Taken by Facility/Agency:

Report made to law enforcement? ☐ Yes ☐ No **Police Case #**_____	Name and address of law enforcement contact

Incident Substantiated by the Facility/Agency ☐ Yes ☐ No

Facility/Agency Investigative Report/Documentation Attached? ☐ Yes ☐ 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: ☐ Yes ☐ 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, Ste 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? ☐ Yes ☐ No Date: _____ AP Terminated? ☐ Yes ☐ No Date: _____

CREDENTIALING/LICENSURE INFORMATION

Certificate or License #: _____ (Attach copy of certificate/license)

Type of Certification (check those that apply) ☐ NAT ☐ CNA ☐ CMA ☐ HHA ☐ AD ☐ SSD ☐ 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): ☐ ACHA ☐ RN ☐ LPN ☐ OT ☐ LMHT ☐ LSW ☐ 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 102 (revised 05/13)