West Virginia Office of the MENTAL HEALTH OMBUDSMAN

PRINTABLE COMPLAINT FORM

Facility Information:			
Name:			
Address:	Street:		
	City:	State:	Zip:

Complaint Information:			
If you wish to be anonymous, please check below. Anonymous complaints will not receive a direct response.			
Do you wish for this complaint to be anonymous?		Yes: ☐	No: ☐
Name:	First:	MI:	Last:
Address:	Street:		
	City:	State:	Zip:
Phone:		Email:	
What is your relationship to the patient, resident, or consumer?			

Affected Patient, Resident, or Consumer Information:			
Name:	First:	MI:	Last:
Age/Date of Birth:			
When did the problem occur?			
What time did the problem occur?			
Where did the problem occur?			
Who are the witnesses, if any?			
What happened?			
Is the problem ongoing?		Yes: ☐	No: ☐
Has this problem happened before?		Yes: ☐	No: ☐

Preliminary Actions Taken:		
Have you spoken to the manager or any staff of the facility?	Yes: ☐	No: ☐
Have you filed this complaint with our office at an earlier date?	Yes: ☐	No: ☐
Are law enforcement agencies involved?	Yes: ☐	No: ☐
What other steps have you taken?		
How did you hear about the Office of the Mental Health Ombudsman?		

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