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| Date Stamp Here: |

**MARION COUNTY HEALTH & HUMAN SERVICES**

**DEVELOPMENTAL DISABILITIES**

**COMPLAINT FORM**

File a complaint when you are not getting the service you think you should get, or when a decision is made about a service you are getting and you do not think it is the right decision for you. Answer the questions below. Suggestions for who can help you and more information are on the back of this form.

**Name of person receiving services:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Service Coordinator (Case Manager):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Telephone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complainant Name (if different):** ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complainant Contact Address/Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of person making Complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Complaint mailed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **What is the problem? What do you want to happen?** (You may attach additional paper if necessary) |

**Signature of person receiving Complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Complaint received (date stamp above):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of person sending Acknowledgment Letter:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Acknowledgment Letter:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Complaint Decision or Outcome (To be completed by Marion County I/DD Services):**  |

**Signature of authorized staff/position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Outcome Letter Mailed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| * I am not satisfied with the decision about my complaint
* I request a Review of the Outcome
* I request an ODDS review
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**A description of the complaint and review process is on the back of this form.**

***Complaint and Review Process***

You may want to ask someone to help you complete the Complaint form. Some examples of who may help you are: a family member, a friend, your Service Coordinator or Personal Agent, your provider.

Return the form to either the Community Developmental Disability office in your County. You may also give it to your Service Coordinator or Personal Agent to turn in for you. CDDP address:

Marion County Intellectual Developmental Disabilities Services 3180 Center St NE

Salem, OR 97301

You should receive a written response to your complaint within 45 days from the date the Community Developmental Disabilities Program received your complaint. The response will be on this Complaint form, with pages attached as needed. If you are not satisfied with the outcome of your complaint, you may request a review of the decision by the Office of Developmental Disability Services (ODDS).

You *must* make the request for a review within 30 days of the date of the decision by the Community Developmental Disabilities Program.

You make that request by checking the box at the bottom of the form. You may either request the Community Developmental Disabilities Office staff send the form to ODDS or you may send it to:

Department of Human Services

Office of Developmental Disability Services

Attention: ODDS Complaint Coordinator

500 Summer Street NE, E09

Salem, OR 97301-1076

Fax: 503-373-7274

ODDS will review your request for review, the response that was provided to you and any additional information provided by you or the CDDP. That response will either agree with the original outcome, will not agree with the outcome, or will suggest some revisions to the outcome.

You will receive a response letter from ODDS within 45 days of your request for a review being received by ODDS.