



## Health Facilities Commission Complaint Form

**Submit this form to the Health Facilities Commission (HFC) electronically by selecting SUBMIT below. Answer all questions that pertain to your situation as completely as possible. Please type or print legibly.**

### Section 1. Complainant Information

*Note: If you wish to remain anonymous, skip to Section 2 – Health Care Facility Information. If anonymous, our office will not be able to contact you to obtain additional information or to notify you of the results of the investigation.*

Name (First and Last):

Address:

City:

State:

Zip Code:

Email Address:

Work Telephone Number:

(     )

Home Telephone Number:

(     )

Cell Telephone Number:

(     )

Best time(s) to contact you (please check all that apply):

Morning

Afternoon

Evening

Date you filed the complaint (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

### Section 2. Health Care Facility Information

Facility Name:

Address:

City:

State:

Zip Code:

Telephone Number: (     )

### Section 3. Resident Information

Resident Name (Last, First):

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Your Relationship to the Resident:

Resident (self)

Friend

Ombudsman

Law Enforcement Agency

Legal representative/guardian/power of attorney

Other, please explain: \_\_\_\_\_

Family Member (Spouse/Child/Parent)

Present or former nursing home employee

Quality Improvement Organization

Media

Anonymous

Is the resident still in the facility?

Yes

No

Unknown



# Health Facilities Commission Complaint Form

## Section 4. Complaint

Please provide as much detail as possible such as date(s), time(s), timeline of events, frequency of occurrence, and full name(s) of any staff members (include title, if known), residents, or witnesses involved. If known, please include the involved resident's date of admission and any pertinent medical history. You may attach additional pages, photos, and/or files to this form, as needed.



# Health Facilities Commission Complaint Form

## Section 5. Reporting Status

Did you report this complaint to the facility staff?  Yes  No

*If yes, please complete the items below.*

A. Date the complaint was reported to the facility staff member: \_\_\_\_/\_\_\_\_/\_\_\_\_

B. Name and title of the facility staff member to whom the complaint was reported:

Name (Last, First): \_\_\_\_\_

Contact Information, if known: (     )

C. What action, if any, was taken by the facility?

D. Did you report this complaint or incident to any other agency?

- |  |   |
|--|---|
| <input type="checkbox"/> Long-Term Care Ombudsman  | <input type="checkbox"/> Law Enforcement Agency |
| <input type="checkbox"/> Adult Protective Services | <input type="checkbox"/> Attorney General       |
| <input type="checkbox"/> Other, please list: _____ |   |

**To submit the complaint form by mail,  
please return the completed form to:**

Centralized Complaint Intake Unit  
Health Facilities Commission  
665 Mainstream Drive, 2nd Floor  
Nashville, Tennessee 37243

**To submit the complaint form by fax or email,  
please return the completed form to:**

Fax Number: 615-253-4356  
Email Address: HFC.Complaints@TN.gov

**To submit a complaint by phone:**

Complaint Hotline: 877-287-0010  
Home Health Compliant Hotline: 800-541-7367

**Hours of Operation:** Monday through Friday 8:00 AM to 4:30 PM  
CST, excluding all State and Federal holidays