

Complaint Form for
[Certified Specialized Developmental Disabilities Community Based Service Providers](#)

For information, complaints or issues related to other Developmental Disability Services including eligibility, please visit the DHHS [DDD](#) website

For complaints related to other types of services or facilities, please visit the DHHS [Facility Complaints](#) website

Please complete as much information as possible to help ensure the proper follow up.

| | |
|--|-------------------|
| Name(s) of Individual(s) receiving services involved in the complaint: | |
| | |
| Name(s) of Certified Specialized Service Provider(s) Involved: Certified DD Provider List | |
| | |
| Location of incident involved: | |
| Physical address: | |
| Apt. or Room #: | |
| Town/City: | |
| Date of incident: | Time of Incident: |
| All certified providers are required to have an internal complaint system. Have you talked to the provider about this issue? <input type="checkbox"/> Yes <input type="checkbox"/> No* | |
| Have you talked to the person's service coordinator about this issue? <input type="checkbox"/> Yes <input type="checkbox"/> No* | |
| Have you reported this situation to any other agency? <input type="checkbox"/> Yes <input type="checkbox"/> No* | |
| If yes to any, please provide information about who you talked to, when, and any other pertinent information. You may attach an additional page if needed.* | |
| | |
| *Although no other notifications are required to file a complaint, doing so may resolve issues more quickly and easily. Information about previous reports increases the speed and accuracy of this unit's next steps. | |
| What occurred to result in this complaint? You may provide an additional page if needed. | |
| | |
| Please list any other witnesses to the incident: | |
| Name | |
| Phone number if known | |
| Witness relationship to person receiving services (if any) | |
| | |
| Your name: | |
| Your relationship to the person: | |
| May we contact you if additional information is needed? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| How may we contact you? (address, telephone number, &/or email address) | |
| | |

Completed form may be mailed to:
DHHS Division of Public Health,
CBS DD Surveyor Complaint, P.O. Box 94669, Lincoln, NE 68509-4669
Or faxed to (402)742-2352 or sent by secure email to DHHS.CBSCert@Nebraska.gov

Please note that due to confidentiality requirements, it may not be possible to release the outcomes or information generated as a result of this complaint even to the person submitting the complaint.

10.18.2017