Washington State Long-Term Care
OMBUDSMAN PROGRAM

GRIEVANCE FORM

Please complete each section of this form and provide as much detail as possible. You may attach an additional sheet if needed. If you are unable to submit this form in writing, please call the Office of the State Long-Term Care Ombuds at 1 800-562-6028 to obtain assistance with documenting your concerns.

Please send this form according to the instructions on page 2 of the attached policy. Alternatively, you may submit it to the Office of the Washington State Long-Term Care Ombuds (by email, fax, or mail), and it will be routed to the appropriate supervisor.
email: ltcop@mschelps.org
fax: 253.815.8173
mail: LTCOP, PO Box 23699, Federal Way, WA 98093

GRIEVANT'S CONTACT INFORMATION	
Last Name:	First:
Email Address	Phone Number:
Mailing Address (If you send the grievance by postal mail):	
Grievant' s Relationship to Resident:	
Date of Filing:	

LONG-TERM CARE OMBUDS INFO
Name of LTC Ombuds involved:

DID THE OMBUDS ACTION TAKE PLACE WHILE PROCESSING A COMPLAINT ON BEHALF OF THE RESIDENT, OR WAS A RESIDENT INVOLVED IN ANY WAY?

☐ YES
If yes, please see page 1 of attached policy regarding resident consent, and please provide the resident's contact information in the following section.

☐ NO

☐ UNSURE

RESIDENT INFORMATION	
Last Name:	First Name:
Also Known As:	Resident's Phone Number (optional):
Name of Facility:	
Facility Location (Address/City):	

DESCRIBE THE SPECIFIC ACTION OF CONCERN, INLCUDING DATES IF YOU KNOW THEM.

PLEASE PROVIDE NAMES OF ANY WITNESSES AND THEIR ROLES (E.G., NURSE, DAUGHTER, ROOMMATE, ETC).

PLEASE DESCRIBE ANY ATTEMPTS YOU MADE TO RESOLVE THIS GRIEVANCE INFORMALLY.

PLEASE DESCRIBE A RESOLUTION OF THIS GRIEVANCE THAT WOULD BE ACCEPTABLE TO YOU.

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT YOU THINK WOULD BE HELPFUL.

PLEASE ATTACH OR FORWARD ANY RELEVANT DOCUMENTS RELATED TO THIS GRIEVANCE (E.G., CORRESPONDENCE).