

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Division of Aging and Adult Services

**OMBUDSMAN CASE**

**TO BE COMPLETED WHEN A COMPLAINT IS RECEIVED BY THE CERTIFIED OMBUDSMAN PROGRAM.  
SEND A COPY TO THE STATE OMBUDSMAN**

OMBUDSMAN'S NAME

CLIENT NAME

1. TYPE OF FACILITY:

- Skilled Nursing Facility                       Unlicensed Home                       Assisted Living Center  
 Assisted Living Home                       Adult Foster Care                       Other (Q Complaint Category Only)

2. NAME OF FACILITY THAT ORIGINATED COMPLAINT

REGION:

- Region One                       Region Two                       Region Three                       Region Four  
 Region Five                       Region Six                       Region Seven                       Region Eight

DATE RECEIVED

DATE OF INITIAL CONTACT

DATE CLOSED

3. CLIENT TYPE

- Group  
 Individual

GENDER

- Female  
 Male

ETHNIC CATEGORY

- Native American Indian                       Asian                       Black/African-American                       Caucasian  
 Hispanic                       Unknown/multi                       Other (specify)

4. REPORTING SOURCE

- Resident                       Facility staff                       Relative/friend  
 Social service program                       Non-relative/guardian/legal representative                       Medical person/physician/staff  
 Ombudsman                       Unknown/anonymous                       Other (specify)

**Complaint Code Table**

Record the complaint categories as applicable. One category per complaint.

Complaint Code (use Reference Code Table)	Finding Code		Disposition Code	Disposition Code (see below)
	Verified or Partially Verified	Not Verified		
	<input type="checkbox"/>	<input type="checkbox"/>		1. Partially resolved but some problems remain. 2. Complaint was not resolved to the satisfaction of resident or complainant.
	<input type="checkbox"/>	<input type="checkbox"/>		3. Resolved to the satisfaction of resident or complainant. 4. No action needed/appropriate.
	<input type="checkbox"/>	<input type="checkbox"/>		5. Resident or complainant request withdrawn. 6. Policy, regulatory or legislative action required to resolve.
	<input type="checkbox"/>	<input type="checkbox"/>		7. Referred to another agency – no action. 8. Referral/no final report 9. Referred to another agency not substantiated

**Nature of Complaint**

Equal Opportunity Employer/Program ♦ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact (602) 542-4446; TTY/TDD Services: 7-1-1.