



Money Follows the Person Participant Complaint Form



MFP Field Personnel: using the text boxes provided, 1) enter the participant's identifying information 2) summarize the issues and enter the action plan/process improvement/follow-up time frames, and 3) in the table provided, enter the vendor's information and identify the service that is the focus of the complaint using the drop down menu. Complete a separate form for each complaint and for each service.

1) Participant First Name:	Participant Last Name:
Participant Medicaid ID#:	Date of Birth (mm/dd/yyyy):
Address:	City: Zip: County:
Participant Phone Number:	Other Contact Name:
Other Contact Phone Number:	
Discharge Date (mm/dd/yyyy):	Waiver Name: Or <input type="checkbox"/> Check for MFP CBAY
MFP Field Personnel Name:	Phone:
Date of Complaint (mm/dd/yyyy):	Name of Person Completing Form:

2) Summary of Complaint/Issues to Resolve:

Action Plan:

Process Improvement (what was instituted to evaluate the action plan and reduce risk to the participant?)

Define follow-up time frames (Act/Monitor) for evaluating effectiveness of process:

3) Enter vendor and use the drop down menu to select the service that is the focus of the complaint:

Vendor	MFP Transition Service
Vendor	MFP CBAY Transition Service

Note: Send the completed form to the DCH MFP Office via FTP or by fax to the MFP Project Director, Pam Johnson at 770-408-5883.