



# MFP Participant Complaint Form



Use this form to report a complaint regarding a MFP service delivered to a participant. Complete separate form for each complaint and for each service.

**Participant First Name:** **Participant Last Name:**  
**Participant Medicaid #:** **Date of Birth (mm/dd/yyyy):**  
**Participant Address:** **City:** **Zip:**  
**Participant Phone Number:** **Other Contact Name:**  
**Other Contact Phone Number:**  
**Discharge from NF/Institution (mm/dd/yyyy):** **Waiver Name:**  
**MFP Facilitator Name:** **Phone:** **Email:**  
**Date of Complaint (mm/dd/yyyy):** **Name of Person Completing Form:**

**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:**

**If applicable, complete information and select the MFP service that is focus of complaint:**

<b>Vendor</b>	<b>MFP Transition Service</b>

**Note:** (1) Send this completed *Participant Complaint Form* to the DCH/MFP Office via File Transfer Protocol.