



Money Follows the Person 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 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:

MFP Field Personnel Name:

Phone:

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:

Vendor	MFP Transition Service

Note: Send this completed *Participant Complaint Form* to the DCH MFP Office via File Transfer Protocol or by fax to the MFP Project Director, Pam Johnson at 770-408-5883.