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DHS Oregon Department of Human Services

AGING AND PEOPLE WITH DISABILITIES
Provider Relations Unit

Oregon Health Authority

Adult Foster Home Provider Complaint Form

Please note:

- Forms must be completed, signed and dated by the licensed AFH provider to be accepted as an AFH Provider Complaint. Incomplete forms will be returned for completion;
- The Provider Complaint Resolution process may take several weeks for research and analysis of the issue through several levels of program and management staff and;
- The AFH provider may withdraw the complaint at any time via email, telephone, fax or mail.

Date submitted:

Provider type:
☐ Aging and People with Disabilities (APD)
☐ Relative APD
☐ Developmental Disabilities (DD)
☐ Mental Health (MH) ☐ Relative MH

Provider information

Provider name:			Medicaid ID number:
Facility name *(if applicable)*:			
Physical street address:			
City:	State:	County:	Zip code:
Phone number:	Fax:	Email address:	
Mailing address *(if different)*:			
City	State:	County:	Zip code:
Phone number:	Fax:	Email address:	

Client information

Client name:	Prime ID:	Incident date *(if applicable)*:

If regarding a SNAP assessment or rate

If you are referencing a SNAP assessment or SNAP assessment rate, please complete the following SNAP information.

Assessor name:			SNAP assessment date:
Was the provider present at the SNAP assessment?	☐ Yes	☐ No	
Was the provider a respondent at the SNAP assessment?	☐ Yes	☐ No	

Continue on next page.

Narrative

Description of question, concern or incident *(be detailed and specific)*: Attach additional pages and supporting documentation, if necessary.

Case manager

Did you contact the client's case manager or service coordinator to resolve this issue? ☐ Yes ☐ No	
Client's case manager/service coordinator name:	Date contacted regarding issue:
What was the resolution or directive of the client's case manager/service coordinator? Attach additional pages, if necessary.	
Was this resolution satisfactory? ☐ Yes ☐ No If no, why was this resolution unsatisfactory? Attach additional pages, if necessary.	

Local branch manager

Did you contact the local office branch manager to resolve this issue? ☐ Yes ☐ No	
Local branch manager name:	Date contacted regarding issue:
What was the resolution or directive of the local branch manager? *(Attach additional pages, if necessary.)*	
Was this resolution satisfactory? ☐ Yes ☐ No If no, why was this resolution unsatisfactory? *(Attach additional pages, if necessary.)*	

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For more information regarding AFH provider complaints and other program information, please review the Provider Tools page here: http://www.oregon.gov/DHS/spd/Pages/provtools/afh-apd/index.aspx.

Continue on next page.

Complete forms must be submitted via email, fax or mail.
Submit this form to:
Email: Provider.ComplaintResolution@state.or.us
Fax: 503-947-5357
Mailing address: DHS, APD
AFH Provider Complaint Resolution, E-12
PO Box 14960
Salem, OR 97309