Complaint No: _____ Date Received: _____

KENTUCKY BOARD OF LICENSURE FOR LONG-TERM CARE ADMINISTRATORS
Complaint Form

Person Filing Complaint

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Telephone: ( ) - _____ Evening Phone: ( ) - _____

Administrator Information
(If Applicable)

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Telephone: ( ) - _____ Evening Phone: ( ) - _____

Relationship to person filing complaint: _____

Name of Facility

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Telephone: **( ) -** _____

Name and phone number of persons who may provide additional information

1. Name: _____ Telephone: ( ) - _____ Type of Information: _____
2. Name: _____ Telephone: ( ) - _____ Type of Information: _____
3. Name: _____ Telephone: ( ) - _____ Type of Information: _____
4. Name: _____ Telephone: ( ) - _____ Type of Information: _____

Brief Summary of Complaint

(Please be specific as possible regarding names, dates, locations, and action which you believe to be improper, unethical or unprofessional. Please attach copies of any documents or records pertinent to your complaint.)

By signing this complaint form, I hereby certify that the information is complete and true to the best of my knowledge.

Signature: _____ Date: _____

If your complaint concerns your treatment by the Long-Term Care Administrator, please sign and enclose the "Client Agreement to Release Information" form.

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Send to: **KENTUCKY BOARD OF LICENSURE FOR LONG-TERM CARE ADMINISTRATORS**
PO BOX 1360
FRANKFORT, KY 40601

Phone: (502)564-3296
Fax: (502)564-4818

Authorization for Release of Records to the Kentucky State Board of Long-Term Care Administrators

I, _____ , the undersigned, do hereby authorize the full
(Print Name Here)
release of any and all medical records and billing information from

_____, _____ Licensed/Certified/ Administrator, regarding

the treatment of a patient at the facility to the Kentucky Board of Licensure for Long-Term Care Administrators or any authorized agent or investigator of the board.

I understand that the above records may be used by the Board in the investigation and possible disciplinary prosecution under 201 KAR 6:090 against the Administrator. I further understand that the Board will make reasonable efforts to protect the confidentiality of my records under KRS Chapter 61 and KRS Chapter 13B, or other applicable law.

A photocopy of this authorization shall be deemed as an original.

This authorization shall be effective for one year from the date of signing.

_____ _____

Date

Signature of patient, or parent/legal guardian of patient if under 18 years of age.