Florida's Long-Term Care
OMBUDSMAN PROGRAM

Our strength is in our unity of purpose

A Department of Elder Affairs Program
4040 Esplanade Way
Tallahassee, FL 32399-7000
888.831.0404
850.414.2377 (F)
http://ombudsman.myflorida.com

Case Investigation - CONFIDENTIAL

Ombudsman Information

District Name: _____
Case #: _____
Lead Ombudsman: _____
Ombudsman #2: _____
Ombudsman #3: _____

Intake Date: _____
Compliance Date: _____
Initial Contact Date: _____
Investigation Completed: _____
Date Closed by Council: _____

Facility Information

Facility Name: _____
Address 1: _____
Address 2: _____
City and Zip: _____
Facility Phone #: _____

Facility Type: _____
Type of License: _____
# of beds: _____
Resident Census: _____
Medicare/Medicaid Certified: _____

Resident Information

Resident Name: _____
Address 1: _____
Address 2: _____
City Name and Zip: _____
Resident Phone #: _____

Birth Date: _____
Gender: _____
Resident Consent: _____
Resident's Legal Rep: _____
Relationship of Legal Rep: _____

Complainant Information

Complainant Name: _____
Address 1: _____
Address 2: _____
City Name and Zip: _____
Phone #: _____
Work Phone #: _____
Cell Phone #: _____

# of Residents Affected: _____

Relationship to Resident: _____
Permission to Disclose Complainant's Name _____
Advised Complainant to Contact AHCA/APS? _____

Case Statement

Hours spent on case: _____
Miles traveled: _____
Expenses: _____

Ombudsman's signature: _____
Date completed investigation: _____

General Information (*One complaint per page*)

District Name: _____ Resident Name: _____

Case #: _____ Facility Name: _____

Lead Ombudsman: _____ City Name and Zip: _____

Complaint Information

Complaint Code: _____

Complaint Statement:

Verification and Disposition Information *(Ombudsman must complete this section before closure)*

Verification Code: _____

V-Verified ***NV-Not verified***

(In order to verify a complaint, it is determined after work that the circumstances described in the complaint are generally accurate.)

Disposition Code: _____

(1-Requires legislative change; 2-Not resolved; 3-Withdrawn; 4-Referred, no report; 5-Referred,agency failed to act; 6-Referred, agency did not substantiate; 7-No action needed; 8-Partially Resolved; 9-Resolved)

Resolution Statement:

Case Recording Form *(use additional pages as necessary)*

Date/ Time	1. Contact complainant within 7 calendar days. 2. Visit the resident and obtain consent. If resident is uable to give permission, contact legal representative to obtain consent. 3. Record what actions you took to resolve the complaint. 4. Follow-up whether the complaint was resolved or not. Complaints should be resolved to the satisfacition of resident(s)

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Consent to Release Information

Case #: _____

Complainant Consent

I, _____, hereby give permission to _____, certified Long-Term Care Ombudsman, or other representatives of the Office of State Long-Term Care Ombudsman, to:

- Y N **Disclose my identity to the resident**
- Y N **Disclose my identity to the facility's administration/staff**
- Y N **Disclose my identity to other agencies in order for the Long-Term Care Ombudsman to investigate and resolve this complaint**

I understand that I may withdraw this consent at any time. This consent will automatically expire when the activities I have authorized the Office of State Long-Term Care Ombudsman to conduct are complete.

Signature of Complainant	Signature of Ombudsman if Verbal Consent Obtained	Date

Resident Consent

I, _____, hereby give permission to _____, certified Long-Term Care Ombudsman, or other representatives of the Office of State Long-Term Care Ombudsman, to:

- Y N **Open a case investigation and proceed with advocacy to resolve this complaint**
- Y N **Access and make copies, if needed, of the following records pertinent for the Office of State Long-Term Care Ombudsman to advocate and resolve this complaint:**
  - ☐ **Medical records**
  - ☐ **Financial records**
  - ☐ **Social records**
  - ☐ **All records**
- Y N **Disclose my identity and relevant information regarding this complaint to other agencies in order for the Long-Term Care Ombudsman or other agencies to investigate and resolve this complaint**
- Y N **Disclose my identity to the facility's administration/staff**

I understand that I may withdraw this consent at any time. This consent will automatically expire when the activities I have authorized the Office of State Long-Term Care Ombudsman to conduct are complete.

Signature of Resident	Signature of Ombudsman if Verbal Consent Obtained	Date
Signature of Legal Representative	Consent granted by: ☐ **Resident** ☐ **Legal Representative** _____	