State of Illinois
Illinois Department of Public Health

Office of Health Care Regulation
Health Care Facility Complaint Form

Illinois Department of Public Health
Office of Health Care Regulation
Central Complaint Registry
525 W. Jefferson St., Ground Floor
Springfield, IL 62761-0001
Fax Number: 217-524-8885
Email Address: dph.ccr@illinois.gov

Central Complaint Registry Hotline – 800-252-4343
TTY for the Hearing Impaired Only – 800-547-0466
Available 24 hours a day - 7 days per week

Directions: You may download this form, complete the information, and mail, fax, or email it to the Illinois Department of Public Health's Central Complaint Registry at the address/numbers provided above. Please be sure to fill out the form completely so a proper investigation may be completed.

Complaints submitted on this form are limited to occurrences in hospitals, home health agencies, hospices, end-stage renal dialysis units, ambulatory surgical treatment centers, rural health clinics, critical access hospitals, free standing Emergency Center, clinical laboratories (CLIA), outpatient physical therapy, alternative healthcare delivery, portable X-ray services, community mental health centers, accredited mental health centers (only Medicare Certified), comprehensive outpatient rehabilitation facilities, health maintenance organizations (HMOs), nursing homes, skilled nursing homes, licensed facilities for individuals with intellectual disability, and assisted living facilities. The Department's Central Complaint Registry is limited to mandates provided in the licensing acts, regulations, and federal Medicare Conditions of Participation or coverage for the programs the Department manages.

Emails, facsimiles, and mailed complaint forms that are sent/received after 4:30p.m. will not be seen until next business day. If a resident's immediate health and/or safety are at risk please call 800-252-4343 to speak with an IDPH representative.

Date of Occurrence _____

Facility _____

Address _____ City _____ State ____ ZIP Code _____

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All complaints are handled as quickly as possible based upon severity guidelines and priority standards. If an address is provided, a written response will be sent upon conclusion of the investigation. If an address is not provided, the complaint will be filed as anonymous and a response will not be available. Please allow up to 120 days to receive the response.

Complainant Name _____

Address _____ City _____ State ____ ZIP Code _____

Daytime Telephone _____ Cell _____

Name of Patient/Resident _____

Date of Birth _____ Sex _____

Current Status of Patient (Transferred, Expired, Hospitalized, still in the facility, discharged, if other please explain)

Identify any witnesses to the occurrence by name and title (Mother, Sister, Brother, friend, RN, LPN, CNA, etc.)

_____ _____

_____ _____

Describe what actually occurred. Limit comments to the facts. Identify who, what, when, and where. Describe any physical harm incurred by the patient.

If known, please include if the facility is aware of the situation. Was law enforcement notified? If you reported the incident identify who you reported the incident/complaint to, the date, and any action(s) taken by the facility/law enforcement to assist you.

Add description of what occurred here: