# FEEDBACK FORM

**Directions: Please complete all the sections except the gray one at bottom of page. Mail or fax the form to Consumer Direct at the address or fax number listed below.**

**Name:** _____ **Date:** _____
(Please Print)

**Affiliation** (check one): ☐ **Consumer** ☐ **Caregiver** ☐ **Personal Care Representative**
☐ **Administrative** ☐ **Other** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____ **Email:** _____

Please check the box that applies: ☐ **Compliment** ☐ **Suggestion** ☐ **Complaint**

**Would you like us to contact you?** ☐ **Yes** ☐ **No** **If yes, how:** ☐ **phone** ☐ **email** ☐ **mail**

**Please describe the compliment, suggestion or complaint:**

**Please mail or fax completed form to:**

Consumer Direct Care Network
1005 Terminal Way, Suite 294
Reno, NV 89502
Toll-free Fax: 877-786-4998

For CDCN office use:
Date Received: ____/____/_____ Signature: _____
Action Taken: ☐ Resolved ☐ Not Resolved ☐ Submitted to Program Manager
Plan: (Please use back of form)