



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 125
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)