Services My Way

FEEDBACK FORM

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

Name: ______________________________________ **Date:** _____________

(Please Print)

You are a (Please check): ☐ **Participant** ☐ **Participant's Authorized Representative** ☐ **Participant-directed Worker** ☐ **Agency**

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 District of Columbia
2611 South Clark Street, Suite 700
Arlington, VA 22202
Toll-free Fax: 877-763-2165

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