CONSUMER DIRECT CARE NETWORK

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
1010 Vermont Ave NW, Suite 1003
Washington, DC 20005
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)