

**MARYLAND**  
**Department of Health**  
**Office of Health Care Quality**

Spring Grove Center • Bland Bryant Bldg. • 55 Wade Avenue • Catonsville, MD 21228 • 410-402-8015

**COMPLAINT REPORT FORM**

Complete this form if you have concerns about the health care or treatment that you or a family member received or did not receive. Answer all questions. Give complete details. Use additional sheet, if necessary. You may use this form as a guide when making a complaint by telephone. We will investigate your concerns based on the information that you provide.

You may file an anonymous complaint

**Complete the following questions.**

**I. Name of patient/resident/client involved in the incident:** \_\_\_\_\_

**Sex:**  Male  Female **Age:** \_\_\_\_\_

**II. Health care facility, residence, or community treatment program involved in the incident:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Check the type of facility or program:**  Nursing home  Adult medical day care  Assisted living  
 Hospital  Home health agency  Residential treatment center  Hospice  Dialysis Center  
 HMO  Ambulatory surgery center  Residential services agency  Birthing center  
 Medical laboratory  Developmental disabilities provider  Other. Please specify

\_\_\_\_\_

**III. Witnesses to the incident:**

**Name** **Contact information, if known** (include telephone number)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IV. Person filing complaint or reporting incident (optional).** Note: If you would like a deficiency report that may result from our investigation, please complete this section.

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**May we reveal your identity during the investigation of your complaint?**  Yes  No

**V. Briefly describe the incident or your concerns (use additional paper if necessary):**

Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate. **Note:** If this is an anonymous report, be complete since we will not be able to contact you to obtain missing information.

**VI. Have you reported this incident or concern to the person in charge of the facility, residence or program?**    Yes    No

Address written complaints to the appropriate licensing unit (listed below) and mail to:

Office of Health Care Quality  
Spring Grove Medical Center  
Bland Bryant Building  
55 Wade Avenue  
Catonsville, Maryland 21228

Or submit your complaint to the appropriate OHCQ licensing unit phone:

Nursing homes- (410) 402-8108 Toll-free 877-402-8219  
Hospitals- (410) 402-8016 Toll-free 877-402-8218  
Health maintenance organizations- (410) 402-8016 Toll-free 877-402-8218  
Developmental disabilities programs- (410) 402-8094 Toll-free 877-402-8220  
Assisted living homes- (410) 402-8217 Toll-free 877-402-8221  
Clinical laboratories- (410) 402-8025 Toll-free 877-402-8202  
Home health agencies, hospice programs, residential service agencies, kidney dialysis centers-  
(410) 402-8040 Toll-free 800-492-6005  
Adult day care- (410) 402-8125 Toll-free 877-402-8221