CONSUMER DIRECT CARE NETWORK

FEEDBACK FORM

Directions: Please complete all the sections except the gray one at the bottom of the page. Mail or fax the form to Consumer Direct Care Network (CDCN).

Name: _____ **Date:** _____
(please print)

You are a (please check): ☐ Employee ☐ Consumer ☐ Agency ☐ 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, fax or drop off this completed and signed form to:

Consumer Direct Care Network
8701 Shoal Creek Blvd., Suite 303
Austin, Texas 78757-6809
Toll Free Fax: 1-866-409-5389

For CDCN Office Use:

Date received: _____ (**This form must have a received date stamp**)

Actions Taken: Resolved Scanned and submitted via email to CDMS Quality Improvement

Action Plan: (Please use back of this form)

_____ _____

CDCN Signature Date Printed Name