Health Facilities Commission
Complaint Form

Submit this form to the Health Facilities Commission (HFC) electronically by selecting SUBMIT below. Answer all questions that pertain to your situation as completely as possible. Please type or print legibly.

Section 1. Complainant Information

Note: If you wish to remain anonymous, skip to Section 2 – Health Care Facility Information. If anonymous, our office will not be able to contact you to obtain additional information or to notify you of the results of the investigation.

Name (First and Last):		
Address:		
City:	State:	Zip Code:
Email Address:		
Work Telephone Number:	Home Telephone Number:	Cell Telephone Number:

Best time(s) to contact you (please check all that apply):

☐ Morning ☐ Afternoon ☐ Evening

Date you filed the complaint (mm/dd/yyyy): ____/____/____

Section 2. Health Care Facility Information

Facility Name:		
Address:		
City:	State:	Zip Code:
Telephone Number:		

Section 3. Resident Information

Resident Name (Last, First):	Date of Birth: ____/_____/____

Your Relationship to the Resident:

☐ Resident (self)
☐ Friend
☐ Ombudsman
☐ Law Enforcement Agency
☐ Legal representative/guardian/power of attorney
☐ Other, please explain:_____

☐ Family Member (Spouse/Child/Parent)
☐ Present or former nursing home employee
☐ Quality Improvement Organization
☐ Media
☐ Anonymous

Is the resident still in the facility? ☐ Yes No ☐ Unknown

If no, where was the resident discharged (home, hospital, etc.)? _____

Section 4. Complaint

Please provide as much detail as possible such as date(s), time(s), timeline of events, frequency of occurrence, and full name(s) of any staff members (include title, if known), residents, or witnesses involved. If known, please include the involved resident's date of admission and any pertinent medical history. You may attach additional pages, photos, and/or files to this form, as needed.

Add the Browse/Upload Link

Section 5. Reporting Status

Did you report this complaint to the facility staff? ☐ Yes ☐ No

If yes, please complete the items below.

A. Date the complaint was reported to the facility staff member: ____/____/____

B. Name and title of the facility staff member to whom the complaint was reported:

Name (Last, First): _____

Contact Information, if known:

C. What action, if any, was taken by the facility?

D. Frequency of concerns reported?

E. What is your expected resolution?

F. Did you report this complaint or incident to any other agency?

☐ Long-Term Care Ombudsman ☐ Law Enforcement Agency
☐ Adult Protective Services ☐ Attorney General
☐ Other, please list: _____

To submit the complaint form by mail, please return the completed form to:

Centralized Complaint Intake Unit
Division of Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, 2nd Floor
Nashville, Tennessee 37243

To submit the complaint form by fax or email, please return the completed form to:

Fax Number: 615-253-4356
Email Address: OHCF.Complaints@TN.gov

To submit a complaint by phone:

Complaint Hotline: 877-287-0010
Home Health Compliant Hotline: 800-541-7367

Hours of Operation: Monday through Friday 8:00 AM to 4:30 PM CST, excluding all State and Federal holidays