

**COMPLAINT / SUGGESTION FORM**

To be completed by any individual who would like to report a complaint or make a suggestion about any aspect of the Wraparound Milwaukee program (i.e., Families, Care Coordinators/Transition Specialists, Providers, etc.)

**PRINT Name of Person Filing Complaint or Suggestion** \_\_\_\_\_  
**Date** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Phone Number** \_\_\_\_\_ **Fax Number** \_\_\_\_\_  
What is your association with Wraparound/Project O'YEAH?     Parent/Caregiver     Enrollee   

**Name of Care Coordinator/Transition Specialist** \_\_\_\_\_  
**Agency** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Name of associated Enrollee** \_\_\_\_\_  
*(If relevant to this complaint / suggestion)*

**If a Complaint, Name of Person/Agency Complaint is Against** \_\_\_\_\_

**Details of Complaint or Your Suggestion:** *(Please be specific including names, dates, etc., when applicable.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Please use back of form or attach an additional sheet of paper if more space is needed)*

**If this is a Complaint, what have you done in an attempt to resolve your concern?** *(Please include who you've spoken to and the result of the conversation. Did the Team discuss the concern?)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What would you like to occur as a result of your complaint/suggestion?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Person Completing Form** \_\_\_\_\_

**Supervisor Signature** \_\_\_\_\_

(if completed by Care Coordinator / Transition Specialist)

**Send To:** WRAPAROUND MILWAUKEE  
9201 Watertown Plank Road  
Milwaukee, WI 53226  
Attn: Pamela Erdman - Quality Assurance Director

**Or Fax To:** Pamela Erdman  
Quality Assurance Department  
at (414) 257-7575

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(For Wraparound Use Only)

**To be Completed by Quality Assurance Department / Investigator**

**Person Assigned to Investigate** \_\_\_\_\_ **Date Assigned** \_\_\_\_\_

**Date Received by Investigator** \_\_\_\_\_

**Please complete Investigation and Return to Pam Erdman/Melissa Graham by** \_\_\_\_\_  
(5 working days)

**Results of Investigation:** *(Be specific and include dates, times, names of individuals spoken to, etc.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Investigator's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*NOTE:** Please call Pam Erdman at (414) 257-7608 or Melissa Graham at (414) 257-6024, if unable to complete the investigation by the date indicated above.

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