PARTICIPANT/EMPLOYEE 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.

Name: ______________________________________ Date: ______________
(Please Print)

You are a (Please check): ☐ Participant ☐ Employee ☐ 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 fax, mail or drop off completed and signed form to:

Toll Free Fax: 1-877-898-0417
Consumer Direct Care Network
280 E. Corporate Drive, Suite 150
Meridian, ID 83642-2953

For CDCN office use:

Date Received: ____/_____/_____ Signature: ___________________________________

Action Taken: ☐ Resolved ☐ Not Resolved ☐ Submitted to Program Manager

Plan: (Please use back of form)