Commonwealth Office of the Ombudsman
209 St. Clair St.
Frankfort, KY 40601
Phone: (866) 596-6283

Complaint Form

Personal Information: (all required except phone number or email address)

1. Full Name: _____

2. Address: _____

3. City: _____ 4. County: _____ 5. State: _____

6. Zip Code: _____ 7. Phone Number:_____

8. Email Address:_____

Details of the Complaint:

9. Service Involved (e.g., Medicaid, SNAP, Child Care, Child Support, Child Protective Services, etc.):
_____

10. Description of the Issue: (*Please provide a detailed account of the problem including relevant dates, locations, and specific individuals involved. Detail any previous interactions you have had with service providers regarding this issue, including calls, emails, or in-person meetings. Attach any relevant documents or correspondence that may support your complaint*): _____

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Desired Outcome:

11. Resolution Sought: *(Outline what actions you would like to see taken to resolve your complaint)*

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Consent and Signature:

Consent to Investigate: I hereby consent to the investigation of my complaint by the Ombudsman's Office. If a complaint involves medical or health care, this consent will include access by the Ombudsman's Office to personal data to complete the investigation or review of my complaint.

Signature: Date:

_____ _____

Submission Instructions:

Please submit this completed form to the Commonwealth Office of the Ombudsman by:

Email: kyombud@ky.gov

Fax: (502) 564-9523

Or in person at:

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209 St. Clair Street
Frankfort, KY 40601