

## Direct Service Worker Training Dissatisfaction Form

The information reported on this form will be reviewed by ODA staff to ensure continued compliance set forth in the training program approval requirements by direct service worker training programs. This form is available to the public and maintained in ODA in accordance with its records retention policy.

**Directions:** Print out this form, complete (please print) and return the completed form to the Ohio Department of Aging, ATTN: Direct Service Worker Training Program, OR email an electronic version to [ODAMail@age.ohio.gov](mailto:ODAMail@age.ohio.gov).

### General Information:

Today's date \_\_\_\_\_

Name of Person Submitting Report: \_\_\_\_\_

Title (e.g. consumer, family member, faculty): \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Email Address: \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_ Best time to be reached: \_\_\_\_\_

### Reported Program Information:

Program Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Program Phone: (\_\_\_\_\_) \_\_\_\_\_

1. Have you attempted to resolve this issue/concern in accordance with the Program's grievance and/or appeal policy? No \_\_\_\_ Yes \_\_\_\_ . If yes, please describe the outcome of the grievance and/or appeal in the space below. Attach any additional pages as needed.

2. Does your concern involve the actions or inactions of an individual who holds a nursing license or certificate issued by the Ohio Board of Nursing? No \_\_\_\_ Yes \_\_\_\_ . If yes, please obtain and submit a licensee Complaint form from the Board's Website in the "FORMS" section and submit the **confidential** information as instructed on the form.

3. Provide a narrative description of your concern regarding the home health aide education program that you believe is not in accordance with the Ohio Department of Aging training program approval requirements. Include specific examples of events that have occurred.