12/2006 Revised

Case referred to: **Date:**

____*Information only*
____*Investigation required*
____*DHS/CCL*

NATIONAL OMBUDSMAN REPORTING SYSTEM (NORS)
CASE SPECIFIC INFORMATION

PSA07 Ombudsman Services of Contra Costa County – (925-685-2070)

OMB Name:

Case No._____

Facility Name :

Complainant Name: Phone No.

Complainant Address: :
(Include City and Zip Code)

Relationship of Complainant to Resident (Please circle): (1) Facility Administrator/Staff

(2) Non-Relative/Guardian/Legal Representative (3) Ombudsman (4) Other

(5) Other Medical Person/Physician/Staff (6) Relative/Friend

(7) Representative of Social Service Agency/Program (8) Resident (9) Unknown/Anonymous

10. **Resident's Name:**
(If group of residents, use GROUP for Resident's Last Name)

11. **RESIDENT'S Age**: _____ **Over 75** ____ **Under 60**____ **Gender**: Male Female

Marital Status: Married Widowed Single

Pay Status: Medicare Medical Both Medicare & Medical Private Pay SSI VA Unknown

Share of Cost $_____**per mo** **Rate $**_____**per mo**

RACE: (Circle One) White Black/African American Asian American Indian/Alaskan Native
Native Hawaiian/Pacific Islander American Indian/White Asian/White
Black/White American Indian/Black Hispanic? Yes___ No____ (Check One)
Other _____

12. **Date of Intake**: 13. **Date of First Action**: 14. **Date Closed**:

Estimate Time Spent on Case: Travel: Documentation:
Investigation: Resolution: **Total**:

Additional Time: Travel Documentation, Investigation, Resolution: Date:

Complaint/Problem against administrator, staff, or resident, of nursing facilities, residential care facilities or other individuals or outside agencies**:**

Complaint Investigation/Observation:

Resolution:

(attach addition pages if necessary)