CONSUMER DIRECT CARE NETWORK

FEEDBACK FORM

Instructions: Please use this form to provide your comments regarding any aspects of Consumer Direct Care Network Virginia's (CDCN) services provided through the Virginia Consumer Directed Services program. Please submit this form via mail, fax or email attachment.

Name: _____ **Date:** _____
(Please Print)

You are a (please check): ☐ Consumer ☐ Consumer's Authorized Representative
☐ Employer of Record ☐ Attendant ☐ Agency Representative

Please check the box that applies: ☐ Compliment ☐ Suggestion ☐ Complaint

Please describe the compliment, suggestion or complaint:

Would you like us to contact you? ☐ Yes ☐ No

If yes, please provide your contact information:

Please send the completed form to CDCN by one of the following ways:

Email: InfoCDVA@ConsumerDirectCare.com

Fax: 1-877-747-7764

Mail:
Consumer Direct Care Network Virginia
Virginia Consumer-Directed Services Program
300 Arboretum Place, Suite 410
Richmond, VA 23236

For CDCN office use:
Date Received: ____/____/_____ Signature: _____
Action Taken: ☐ Resolved ☐ Not Resolved ☐ Submitted to Program Manager
Plan: (Please use back of form)

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