CONSUMER DIRECT CARE NETWORK

FEEDBACK FORM

Directions: Please complete all the sections except the gray one at the bottom of the page. Mail, email or fax the form to Consumer Direct Care Network Wisconsin.

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

You are a (Please check): ☐ Member ☐ Employee ☐ Agency ☐ Other _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Email:** _____

Would you like us to contact you? ☐ Yes ☐ No **If yes, how:** ☐ Phone ☐ Email ☐ Mail

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

Please describe the compliment, suggestion or complaint:

Please send to: Consumer Direct Care Network Wisconsin
744 Ryan Drive, Suite 201
Hudson, WI 54016
Toll Free Fax: 1-877-785-9992
Email: InfoCDWI@ConsumerDirectCare.com

For Consumer Direct Office Use

Date Received: ___/___/___ Signature: _____

Action Taken: ☐ Resolved ☐ Not Resolved ☐ Submitted to Program Manager
Plan: (Please use back of form)