

The Child Welfare Services Ombudsman

1-866-621-0758

Instructions:

If you have already talked with your caseworker about your concern and you wish to file a complaint, please fill out this form and return it to the Ombudsman office in the envelope provided. Please answer each question as well as you are able. Also be as specific as you can in describing your complaint.

If you have materials that support concerns, please send us copies along with this form. *Please do not send original copies.*

The information you give us will be used in the event we do a review of your concerns. In order to allow DHHS to respond to your complaint, **the information you provide us will be shared with the Department of Health and Human Services staff.** In addition the information you provide may also result in Ombudsman staff filing a report of child abuse and/or neglect with the Department of Health and Human Services.

If you have an emergency regarding the safety of a child, call the Child Abuse and Neglect 24 hour hotline at **1-800-452-1999** as the Ombudsman office does not handle emergency situations.

If you are unable to fill out this form for any reason, please contact the Ombudsman office directly. We will help by answering questions and by helping you complete the form if needed.

Ombudsman Referral Form

Today's date: _____

How did you first hear about the Child Welfare Services Ombudsman?

- | | | | | |
|--|---|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Friend | <input type="checkbox"/> Relative | <input type="checkbox"/> Service Provider | <input type="checkbox"/> DHHS | <input type="checkbox"/> Police |
| <input type="checkbox"/> Court | <input type="checkbox"/> Attorney | <input type="checkbox"/> Guardian ad Litem | <input type="checkbox"/> Brochure | <input type="checkbox"/> Website |
| <input type="checkbox"/> Legislator | <input type="checkbox"/> Public Legal Aid | <input type="checkbox"/> Health Care Professional | | |
| <input type="checkbox"/> Public Official | | <input type="checkbox"/> Other _____ | | |

Are there any upcoming court dates regarding this child?

If so, please describe.

Child Information

Child(ren) involved with complaint:

To report suspected child abuse or neglect call Child Protective Services at 1-800-452-1999

MAINE CHILDREN'S ALLIANCE
303 STATE STREET, AUGUSTA, ME 04330

If there are more than three children involved with the complaint, please provide the same information on a separate sheet of paper.

Name: _____ Address: _____

Boy/Girl: _____

Date of Birth: _____ Age: _____

Child lives with: _____ (Example: Mother, Father, Foster Home, Residential Treatment, etc.)

Does this child have Maine Care / Medicaid: Yes ___ No ___

Name: _____ Address: _____

Boy/Girl: _____

Date of Birth: _____ Age: _____

Child lives with: _____ (Example: Mother, Father, Foster Home, Residential Treatment, etc.)

Does this child have Maine Care / Medicaid: Yes ___ No ___

Name: _____ Address: _____

Boy/Girl: _____

Date of Birth: _____ Age: _____

Child lives with: _____ (Example: Mother, Father, Foster Home, Residential Treatment, etc.)

Does this child have Maine Care / Medicaid: Yes ___ No ___

Other child(ren) living in the home but not involved with the complaint:

Name: _____ Address: _____

Boy/Girl: _____

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Date of Birth: _____ Age: _____

Child lives with: _____ (Example: Mother, Father, Foster Home, Residential Treatment, etc.)

Does this child have Maine Care / Medicaid: Yes _____ No _____

Name: _____ Address: _____

Boy/Girl: _____

Date of Birth: _____ Age: _____

Child lives with: _____ (Example: Mother, Father, Foster Home, Residential Treatment, etc.)

Does this child have Maine Care / Medicaid: Yes _____ No _____

Guardian ad Litem

Name: _____

Address: _____

Telephone: _____

Your Information:

Name: _____ Address: _____

Telephone: _____

Relationship to Child: _____

Parent(s):

Mother

Name: _____

Address: _____

Telephone: _____

To report suspected child abuse or neglect call Child Protective Services at 1-800-452-1999

Attorney for Mother

Name: _____

Address: _____

Telephone: _____

Father

Name: _____

Address: _____

Telephone: _____

Attorney for Father

Name: _____

Address: _____

Telephone: _____

Friends/family:

Name:	Address:	Relationship:	Tel. Number

DHHS Information:

District Office: _____

Caseworker: _____

Supervisor: _____

If your complaint involves a DHHS case worker:

You have the right to contact the caseworker's supervisor with your complaint. To find out who your caseworker's supervisor is you may contact the main number for the district office in which you are being served.

Legal Status: (Please check all that apply)

Child in State custody

Child in open Child Protective Status

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Child with legal parent

Currently in court

In appeal process

Other

Complaint Summary:

What is your complaint?

Briefly describe the DHHS action or inaction that you are complaining about and the date or dates on which it occurred.

Example: “My child was taken into DHHS custody and placed in a foster home. DHHS is not willing to look at any of my relatives as possible placement options.”

Complaint Summary continued:

Please describe why you think the DHHS action or inaction was wrong or unreasonable?

Include as many facts as you can. If you need more room, you may attach additional sheets of paper and submit materials or copies of documents that support your claim. *Please do not send original documents.*

Example: “My mother and my aunt are both willing to provide care to my daughter.”

What do you hope will happen to resolve your complaint?

Please be as clear as you can.

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Example: "I want the caseworker to consider letting my child live with my mother or my aunt."

Who have you talked to at DHHS regarding your complaint?

Please give the name(s) of the person(s) you have contacted.

Please Note: It is very important that you talk to your caseworker about your concern before sending this referral in.

Other people/agencies involved with the child/family:

Service Providers:

Staff Name: **Agency Name:** **Address:** **Tel. Number**
