Name of individual submitting complaint (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID/Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nature of the Complaint: Please be as specific as possible, including dates, names of individuals involved, and other relevant information. Please attach additional sheets if necessary.

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Do you give your authorization for the Office of Administration, Workplace Support Services Division, SEAP Program Office (OA-SEAP) to investigate your complaint? \_\_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_\_ no

If yes, do you give your authorization to be contacted by OA-SEAP and/or Optum to discuss the situation? \_\_\_\_\_\_ yes \_\_\_\_\_ no

Do you wish your agency and/or local SEAP Coordinator to receive information about the resolution of your complaint? \_\_\_\_\_\_\_yes \_\_\_\_\_\_\_no

If yes, please identify the SEAP Coordinator (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this report being submitted on behalf of another person? \_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_ no

If yes, does this person give their authorization to be contacted by OA-SEAP or Optum to discuss the situation? \_\_\_\_\_ yes \_\_\_\_\_ no. Their signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the desired outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I give my authorization to allow Optum to share information related to the above complaint with OA-SEAP. I understand that the information will be limited to only that information related to my complaint and no other information will be shared. I understand that this authorization expires upon resolution of the complaint.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Member/Legal Guardian Signature of Minor Member Date

or Member’s Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Member’s Representative Relationship to the Member Description of Rep’s Author

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return, Marked Confidential, to:**

# Office of Administration – Workplace Support Services Division

## SEAP Program Office

**613 North Street**

**513 Finance Building**

**Harrisburg, PA 17120**

**(717) 772-3153 Fax**