

CONTINUING CARE RETIREMENT COMMUNITIES COMPLAINT FORM

DFS FILE # _____

To be completed by complainant and returned to the address indicated on the other side:

YOUR NAME: _____

ADDRESS: _____

DAYTIME PHONE NUMBER: () – – _____

RESIDENT'S NAME: _____

COMPANY OR OTHER PERSON INVOLVED IN DISPUTE:

NAME: _____

ADDRESS: _____

DAYTIME PHONE NUMBER: () – – _____

RESIDENT'S NAME: _____

YOUR DISPUTE INVOLVES (Select those that apply):

- Monetary amounts (such as refunds)
- Contract Benefits
- Contract Services
- Resident Issues
- Other _____

Brief statement of the problem:

Signature

Date

Authority for this program is given under section 651.123, Florida Statutes and Department Rule 4-193.062. It is available to all residents for disputes OTHER THAN challenges involving increases in monthly maintenance fees.

Once the provider is notified by the Department of this complaint they will have 21 days to resolve the issue. For good cause, the Department is authorized to extend this period for up to an additional 14 days. You will be mailed an application to request a mediation conference if the problem is not resolved within the appropriate time frame.

Please feel free to contact our mediation office at (850) 413-5818 if you have any questions.

Department of Financial Services
Bureau of Consumer Assistance
Mediation Programs
200 East Gaines Street
Tallahassee, FL 32399-0322