

**Senior Protection
Complaint Form**

seniors@attorneygeneral.gov

www.attorneygeneral.gov



Senior Protection Unit
16th Floor, Strawberry Square
Harrisburg, PA 17120

1-866-623-2137 (Help Line)

**TO REPORT AN EMERGENCY CASE OF ELDER ABUSE DIAL 9-1-1
OR BY CALLING ADULT PROTECTIVE SERVICES 1-800-490-8505**

Required fields are marked with an asterisk*

Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you on active duty? <input type="checkbox"/> Yes <input type="checkbox"/> No		Age Group: <input type="checkbox"/> Under 18 <input type="checkbox"/> 60-64 <input type="checkbox"/> 18-34 <input type="checkbox"/> 65 and older <input type="checkbox"/> 35-59		
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	Name*			
Address*				
City*		State*	Zip Code*	County*
Daytime Phone Number ()	Home Phone Number ()	Email Address		

If you are filling this form out on behalf of someone else, please submit your information:

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	Name*			
Address*				
City*		State*	Zip Code*	County*
Daytime Phone Number* ()	Home Phone Number* ()	Email Address		

Who is the complaint against?

Name		Phone Number: ()	
Address			
City	State	Zip Code	County

**PLEASE READ CAREFULLY
THE ATTORNEY GENERAL CANNOT ACT AS YOUR PRIVATE ATTORNEY**

The primary function of the Office of Attorney General is to represent the public at large. The Senior Protection Unit may mediate your complaint if it falls within the jurisdiction of this office. Be advised that the information you provide may be shared with the party you have complained about and may be shared with or referred to other law enforcement or regulatory agencies.

Your complaint will be kept on file with our office and the information may be used to establish violations of Pennsylvania law.

By signing below:

1. I authorize the Senior Protection Unit to provide a copy of this complaint to any person or entity about which I am complaining; and to any person or provider possessing medical and insurance records or information related to this complaint.

2. I authorize the Senior Protection Unit to transfer my complaint to another federal, state, local, or other agency, which may have jurisdiction over this matter. This authorization extends to any and all attachments which may be part of my case file, including any medical records the Office may obtain pursuant to a medical release. Additional information may be requested.

I certify that the information provided in this complaint form, including my identity and any factual statements or allegations, are true and correct to the best of my knowledge, information, and belief.

YOUR SIGNATURE

DATE

OFFICE USE ONLY

Disposition of the complaint date		Name	
<input type="checkbox"/> OAG Unit	Agent		Complaint #
<input type="checkbox"/> Outside referral to		By	