PENNSYLVANIA OFFICE OF ATTORNEY GENERAL



ELDER ABUSE COMPLAINT FORM ELDER ABUSE UNIT 14TH FLOOR, STRAWBERRY SQUARE

HARRISBURG, PENNSYLVANIA 17120 Fax: (717) 787-1190

1-866-623-2137 (Hot Line)

TOM CORBETT ATTORNEY GENERAL

www.attorneygeneral.gov

VICTIM INFORMATION			AGE RANGE (CHECK BOX PLEASE)
			□ 60-69 □ 70-79 □ 80-89 □ 90+
NAME		DOB	
ADDRESS			
CITY	STATE	ZIP CODE	TELEPHONE NUMBER
COUNTY	HOME TELEPHONE NUMBER		
YOUR NAME		REL	ATIONSHIP TO VICTIM
ADDRESS			
CITY	STATE	ZIP CODE	TELEPHONE NUMBER
HOME TELEPHONE NUMBER	TELEPHONE NUMBER BEST NUMBER		CALL DURING THE DAY
NAME OF THE PERSON OR ENTITY YOUR COMPLAINT IS AGAINST			
ADDRESS			
CITY	STATE	ZIPCODE	TELEPHONE NUMBER

Please explain your complaint. You may use additional sheets if necessary. Please print or type clearly. Try to be brief, but be sure to tell us **WHAT** happened, **WHEN** it happened, and **WHERE** it happened. Be specific about any oral statements that were made to you. Describe events in the order in which they happened. Attach <u>COPIES</u> of all solicitations, letters, receipts, canceled checks (front & back), advertisements and any other papers that relate to your complaint.

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. 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.

By signing below:

1. I authorize the Elder Abuse 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 Elder Abuse 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.