DEPARTMENT OF COMMUNITY HEALTH

RECIPIENT RIGHTS COMPLAINT

COMPLAINT NUMBER	CATEGORY

INSTRUCTIONS:

IF YOU BELIEVE THAT ONE OF YOUR RIGHTS HAS BEEN VIOLATED YOU (OR SOMEONE ON YOUR BEHALF) MAY USE THIS FORM TO MAKE A COMPLAINT. A RIGHTS OFFICER/ADVISOR WILL REVIEW THE COMPLAINT AND MAY CONDUCT AN INVESTIGATION. KEEP THE PINK COPY FOR YOUR RECORDS AND SEND THE OTHER COPIES TO THE RIGHTS OFFICE AT YOUR CMH SERVICES PROGRAM, HOSPITAL, OR TO:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF RECIPIENT RIGHTS
LEWIS CASS BUILDING
LANSING MI 48913

COMPLAINANT'S NAME	RECIPIENT'S NAME (If different from complainant)
WHERE DID THE ALLEGED VIOLATION HAPPEN?	PHONE NUMBER
COMPLAINANT'S ADDRESS	WHEN DID IT HAPPEN? (Date and Time)

WHAT RIGHT WAS VIOLATED?

DESCRIBE WHAT HAPPENED?

WHAT DO YOU WANT TO HAVE HAPPEN IN ORDER TO CORRECT THE PROBLEM?

COMPLAINANT'S SIGNATURE	DATE	NAME OF PERSON ASSISTING COMPLAINANT