## DEPARTMENT OF COMMUNITY HEALTH RECIPIENT RIGHTS COMPLAINT

|              |      |          | _ |
|--------------|------|----------|---|
| COMPLAINT NU | MBER | 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 SERVICES TO THE RIGHTS OFFICE AT YOUR CMH SERVICES PROGRAM, HOSPITAL, OR TO:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH OFFICE OF RECIPIENT RIGHTS LEWIS CASS BUILDING

| LEWIS CASS BUILDING<br>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?  |  |  |
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| DESCRIBE WHAT HAPPENED?   | <del>and de la composition della c</del> |  |
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| WHAT DO YOU WANT TO HAVE HAPPEN IN ORDER TO CORRECT THE PROBLEM | ?  |  |
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| COMPLAINANT'S SIGNATURE DATE                                    | NAME OF PERSON ASSISTING COMPLAINANT   |  |