

**DETROIT WAYNE MENTAL HEALTH AUTHORITY
 RECIPIENT RIGHTS COMPLAINT FORM**

FOR OFFICE USE ONLY	
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 REPRESENTATIVE WILL REVIEW THE COMPLAINT AND MAY CONDUCT AN INVESTIGATION. KEEP A COPY FOR YOUR RECORDS AND SEND THE ORIGINAL COPY TO:

DETROIT WAYNE MENTAL HEALTH AUTHORITY
 OFFICE OF RECIPIENT RIGHTS
 640 TEMPLE - 2ND FLOOR
 DETROIT, MI 48201

COMPLAINANT'S NAME	RECIPIENT'S NAME (If different than complainant)
COMPLAINANT'S ADDRESS	RECIPIENT'S ADDRESS
COMPLAINANT'S PHONE NUMBER	RECIPIENT'S PHONE NUMBER
WHERE DID THE ALLEGED VIOLATION HAPPEN?	WHEN DID IT HAPPEN? (Date and time)
WHAT RIGHT WAS VIOLATED?	
DESCRIBE WHAT HAPPENED	
WHAT DO YOU WANT TO HAPPEN IN ORDER TO CORRECT THE PROBLEM?	
COMPLAINANT'S SIGNATURE	DATE
NAME OF PERSON ASSISTING COMPLAINANT (IF ANY)	

DCH-0030 2/97 REPLACES DCH-2500
 CMH REVISED 2500B (08/06)

AUTHORITY: P.A. 258 OF 1975 AS AMENDED BY P.A. 290 OF 1995