 Macomb County Community Mental Health

**RECIPIENT RIGHTS COMPLAINT**

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| **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 a copy for your records and send the original to **Office of Recipient Rights – Macomb County CMH, 22550 Hall Rd., Clinton Twp., 48036 or Fax to: (586) 466-4131**. You may contact the Office of Recipient Rights if you need assistance at (586) 469-6528. | | | |
| Complainant’s Name: | | Recipient’s Name (if different from complainant): | |
| Complainant’s Address: | | Where did the alleged violation occur? | |
| City and Zip Code: | | When did the alleged violation happen? (date and time): | |
| Complainant’s Phone Number: | | Name of Staff involved: | |
|  | | | |
| What right was violated? | | | |
| Describe what happened: | | | |
| What would you like to have happen in order to correct the violation? | | | |
| Complainant’s Signature | Date | | Name Of Person Assisting Complainant |
| DCH 0030 Replaces DCH-2500 Authority: P.A. 258 of 1974 as amended  Distribution: ORIGINAL TO ORR COPY to Complainant (with acknowledgement letter) | | | |