Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Health Facilities Division
Substance Abuse Program
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

LARA/SUB- 504 (5/13)

RECIPIENT RIGHTS COMPLAINT FORM

Authority: Public Act 368 of 1978, as amended

To Be Completed By Rights Advisor:

Program Name
License Number
Complaint Number
Date Received by Rights Advisor
Date Report Due to Recipient

1. **DESCRIBE YOUR COMPLAINT:** (Does your complaint involve a person, a procedure, or the building the program is in? Give names of witnesses or other details that will help your rights advisor understand your complaint). Attach additional paper if necessary.

_____

_____

_____

_____

2. **Where did it happen?** (Address or Location): _____

_____

3. **When did it happen?** (Date (MM/DD/YY) and Time) _____

4. **What right(s) do you think were violated?** _____

_____

_____

5. **What would you consider to be a fair solution to this problem?** (What do you want done, by whom and by when? _____

_____

6. **How do you want to get your copy of the investigation report on this complaint?** (Check one)

☐ **PICK UP** in rights' advisor's office with 30 working days. When report is ready, please call me at:
_____ _____ (Telephone Number w/area code)

☐ **MAIL** to me at the following address by registered mail:

_____ _____ _____ _____
Street Address City State Zip Code

Recipient's Signature (must also sign authorization to release information on Page 2).

Signature: _____ Date: _____

Rights Advisor's Signature: _____

Printed Name: _____ Date: _____

Copies to: 1) Program 2) LARA/BHCS/SUBSTANCE ABUSE 3) Coordinating Agency

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INSTRUCTIONS FOR THE RECIPIENT/CLIENT
RECIPIENT RIGHTS COMPLAINT FORM

HOW TO FILE A COMPLAINT

A. You should fill out the attached form if you believe one of your rights has been violated.
B. If you need help to write out your complaint, please see your rights advisor.
C. If you are not sure what right was violated, ask your rights advisor for a list of your rights.
D. After you fill out items 1 through 7 on Page 1, sign the authorization to release information form.
E. Give the form to your rights advisor.

WHAT WILL HAPPEN

After you give the completed form to your rights advisor, he or she may ask you for additional information. The rights advisor will then investigate your complaint and try to develop a fair solution.

Within 30 working days of the date your rights advisor receives this form, he or she will give you a written **Recipient Rights Investigation Report**. That report will have a summary of what the rights advisor found while investigating your complaint. It will have a proposed solution (action plan) if your complaint was found to require action.

YOUR RIGHT TO APPEAL

When you receive the *Recipient Rights Investigation Report*, you will have **15** working days to decide to accept the findings and/or action plan proposed by the program, or to file an appeal. If you do not appeal within **15** working days, this indicates/means you have accepted the investigation report.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the _____
Program to release information contained in my program records to my coordinating agency rights consultant or designee and to the substance abuse rights coordinator or designee. I authorize release of information that is necessary for the complete investigation of my recipient rights complaint and any future appeals. The release includes authorization to interview witnesses concerning my complaint when such interviews are necessary for a complete investigation of my complaint.

This authorization is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished.

Without expressed revocation, this authorization expires when the investigation of my complaint or subsequent appeals has been completed.

_____ _____
Signature of Recipient Date Signed

_____ _____
Signature of Witness Date Witnessed

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans With Disabilities Act, you may make your needs known to this agency.