DETROIT WAYNE INTEGRATED HEALTH NETWORK

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 INTEGRATED HEALTH NETWORK
OFFICE OF RECIPIENT RIGHTS
707 W. MILWAUKEE STREET
DETROIT, MI 48202-2943

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 REPLACES DCH-2500

AUTHORITY: P. A. 258 OF 1975 AS AMENDED

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COPY TO – Complainant (with acknowledgement letter)