RECIPIENT RIGHTS COMPLAINT FORM

Date: _______ Client Name: ____________________ Counselor/Worker: __________________

Address: ____

Name of Person filing complaint (if different than Client Name): __________________

What right do you feel was violated? ____

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Date and time it occurred: ____________________________________

Describe what happened: ____

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

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________________________________ ____________________

Client Signature Date

Your complaint will be investigated and you will receive a written report of the findings. This form should be submitted to the agency Clinical Supervisor/Rights Advisor.

________________________________ ____________________

Clinical Supervisor Signature Date Received