104 CMR 32.00

COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF MENTAL HEALTH

COMPLAINT FORM

For Department Use Only

Date Received: ____/____/____

Received By: _____

Log #: _____

1. NAME OF COMPLAINANT(S) STATUS* ADDRESS AND TELEPHONE # (OR PROGRAM NAME)

a. _____

b. _____

c. _____

2. Client(s)Thought to be Harmed by Matter Complained of (if any and if known) ADDRESS AND TELEPHONE # (OR PROGRAM NAME)

a. _____

b. _____

c. _____

3. NAME(S) OF PERSON(S) COMPLAINED OF (if any and if known) STATUS* ADDRESS AND TELEPHONE # (OR PROGRAM NAME)

a. _____

b. _____

c. _____

4. PERSON FILLING OUT FORM (if other than above): _____

5. WHEN DID MATTER COMPLAINED OF OCCUR [Date(s) and Time(s)]? _____

6. WHERE DID MATTER COMPLAINED OF OCCUR? _____

7. Describe what Happened (Continue on back and/or attach additional sheets as necessary): _____

* STATUS: C=Client; E=Employee; H=Human Rights Committee; R=Relative; O=Other (Specify)

7. What Happened (Continued):

[ ] Check here if there are any attachments

IF YOU ARE BETWEEN THE AGES OF 18 AND 59 (INCLUSIVE), AND HAVE BEEN SUBJECT TO PHYSICAL OR EMOTIONAL ABUSE, YOU CAN CALL THE DISABLED PERSONS PROTECTION COMMISSION'S 24 HOUR HOTLINE AT (800) 426-9009.

EMPLOYEES OF THE DEPARTMENT OF MENTAL HEALTH AND OF PRIVATE AGENCIES PROVIDING SERVICES TO DISABLED PERSONS WHO HAVE REASON TO BELIEVE A DISABLED PERSON BETWEEN THE AGES OF 18 AND 59 HAS BEEN PHYSICALLY OR EMOTIONALLY ABUSED ARE REQUIRED BY LAW TO IMMEDIATELY REPORT THE ABUSE TO THE DISABLED PERSONS PROTECTION COMMISSION'S 24 HOUR HOTLINE AT (800) 426-9009. A WRITTEN REPORT SHOULD BE FILED WITH DPPC WITHIN 48 HOURS OF THE ORAL REPORT.

DATE **COMPLAINANT SIGNATURE**