Office on Mental Health

Core Service Agency of Harford County, Inc.

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COMPLAINT FORM

Are you reporting anonymously? Yes No

1. CLIENT NAME AND CONTACT INFORMATION

Name: Dr. Mr. Ms. Mrs.			
	Last	First	MI

Home Address:				
	Street	City	State	Zip Code

Email:	
Home Telephone Number:	
Cellphone Number:	

2. IDENTIFY COMPLAINANT

Are you completing this form on behalf of the client? Yes No

If no, please skip section 3. If yes, please provide the following information in section 3.

3. COMPLAINANT NAME AND CONTACT INFORMATION

Name: Dr. Mr. Ms. Mrs.			
	Last	First	MI

Home Address:				
	Street	City	State	Zip Code

Email:	
Home Telephone Number:	
Cellphone Number:	

4. RELATIONSHIP OF COMPLAINANT TO CLIENT

Client (self)	Spouse	Parent	Legal Guardian	Other:

5. PROVIDER NAME AND CONTACT INFORMATION

Name: Dr. Mr. Ms. Mrs.			
	Last	First	MI

Agency/Office:				
Business Address:				
	Street	City	State	Zip Code
Business Telephone Number:				

6. LIST THE DATE(S) TREATED BY THIS HEALTH CARE PROVIDER

7. WHAT ARE THE DETAILS OF YOUR CONCERN? Provide specific details, including dates, times, locations, and all persons involved.
8. WHAT STEPS HAVE YOU TAKEN TO ADDRESS THE ISSUE?
9. WHAT OTHER INDIVIDUALS, INCLUDING ANY OTHER HEALTH CARE PROVIDERS, HAVE KNOWLEDGE OF YOUR COMPLAINT? Please provide names, addresses, and telephone numbers.
10. ADDITIONAL COMMENTS: