UMassMemorial Community Healthlink

Community Healthlink
COMPLAINT FORM

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)	**Status***	**ID number and 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 (Dates and times)?

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)

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7. What happened (Continued):

☐ Check here if there are any attachments

IF YOU ARE BETWEEN THE AGE OF 18 AND 59 (INCLUSIVE) AND HAVE BEEN SUBJECT TO PHYSICAL OR EMOTIONAL ABUSE YOU CAN CALL THE DISABLED PERSONS PROTECTION COMMISSION 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 AGE OF 18 AND 59 HAS BEEN PHYSICALLY OR EMOTIONALLY ABUSED ARE REQUIRED BY LAW TO IMMEDIATELY REPORT ABUSE TO THE DISABLED PERSONS PROTECTION COMMISSION 24 HOUR HOTLINE AT (800) 426-9009. A WRITTEN REPORT SHOULD BE FILED WITH DPPC WITHIN 48 HOURS OF THE ORAL REPORT.

All forms should be sent to the following: Program Management, Program Director, AND the Compliance Office, 72 Jaques Avenue, Worcester, MA 01610**.** Compliance Fax: (508) 860-1023

DATE

COMPLAINANT SIGNATURE