

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Bureau of Health Systems

RESIDENT ASSISTANCE FORM (Example)

[Facility Name]

Please give us an opportunity to address your concerns by completing this form. There is information posted that lists the person available 24 hours a day for your assistance.

INFORMATION ABOUT PERSON REQUESTING ASSISTANCE		
Name (Please Print):		
Are you a resident living in this facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	If "Yes", what is your Room #?	
If "No", does this relate to a particular resident? Resident's Name:	What is your relationship to that resident? <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Other (explain):	
Street Address (if not resident):		
City:	State:	Zip Code:
INFORMATION ABOUT YOUR CONCERNS		
WHAT is your complaint about? (Attach additional sheets if necessary.)		
WHEN did the problem or incident occur?	Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
WHO ELSE KNOWS about the problem or incident? (Include title of facility staff if you know them.)		

BHS-106 (Rev. 6/10)
 Authority: P.A. 368 of 1978, as amended

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this agency under the *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.

HOW can we address your issues?

Is this an ongoing problem?

Yes NO

If “Yes,” for how long?

Have you contacted us in the past about this complaint? Yes NO

If “Yes,” to whom?

Your Signature:

Date:

FACILITY RESPONSE

ACTION TO BE TAKEN

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Signature (Facility):	Date:
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<input type="checkbox"/>	I am satisfied with the response to my request for assistance.
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<input type="checkbox"/>	I am not satisfied with the response to my request for assistance. I request that the administrator review my complaint and provide me with a response.
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Signature (Complainant):	Date:
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FACILITY FOLLOW-UP

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Signature (Facility):	Date:
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**INSTRUCTIONS FOR REQUESTING ASSISTANCE FROM STAFF
OF (Name of Facility)**

We are committed to providing the highest quality of care to residents in our facility. We want you to feel safe in a homelike environment. In order for us to assist you, please follow the procedure identified below if you have any concerns about your care, treatment by staff, or anything else related to your stay in our facility.

- Step 1** Tell the **(staff person on each shift designated to handle complaints)** of your concerns.
- Step 2** If not satisfied with the staff person's response, complete our *Resident Assistance Form*. Let us know if you need help in completing the form.
- Step 3** Submit the form to **(the person designated by the facility to receive and investigate complaints)**.
- Step 4** If not satisfied with the facility's written response, complete a request for the administrator to review the investigation findings.
- Step 5** If not satisfied with the Administrator's resolution, you may contact the State Ombudsman or the Michigan Department of Community Health, Bureau of Health Systems, to file a formal complaint.

WE WANT YOU TO KNOW THE FOLLOWING:

1. We will keep your request as confidential as possible.
2. Our timeframes for investigating your concerns are:
 - (A) *Immediately (no later than 8 hours)* – for abuse, neglect or misappropriation.
 - (B) *As Soon As Possible but Within 5 Days* – for anything that has caused actual harm.
 - (C) *As Soon As Possible but Within 15 Days* – for any other concern.
3. **We will give you a written response as soon as possible but no later than 30 days after we receive your request.**
4. **We will follow-up to ensure your concern has been addressed satisfactorily and use the findings of our investigation as part of our Quality Improvement Program – again keeping your name confidential, if possible.**
5. You may contact the **Michigan Department of Community Health, Bureau of Health Systems, at 1-800-882-6006** to file a complaint, or the **State Ombudsman at 1-866-485-9393** for assistance at any time.