18. Miscellaneous

Attorney Grievance Form
Bureau of Health Systems Complaint – LPH Poster Information
Bureau of Health Professions Complaint Instructions/Forms
Resident Patient Care Complaint
Adult Foster Care Complaint
SUD Complaint
SUD Rights Poster
SUD Confidentiality Regulations and Release
Civil Rights Complaint
HIPAA Complaint via MDCS Civil Rights
Resources Necessary to Run the Office
ORR Case File Sheet

ATTORNEY GRIEVANCE COMMISSION
State of Michigan

Welcome

The Attorney Grievance Commission (AGC) is the investigative and prosecutorial arm of the Michigan Supreme Court for allegations of attorney misconduct. The AGC serves to maintain and promote the integrity of the Bar and to protect the public, the courts, and the legal profession. The AGC has jurisdiction over all attorneys licensed to practice law by the State Bar of Michigan and attorneys otherwise permitted to practice law in the State of Michigan.

In exercising its investigative and prosecutorial powers, the AGC strives to promptly and efficiently hold attorneys accountable for their misconduct or determine that the allegations do not merit formal disciplinary action. The basis for AGC action is a violation of the Michigan Rules of Professional Conduct and/or limited applications of the Michigan Court Rules.

The Attorney Discipline Board is the adjudicative arm of the Michigan Supreme Court for matters in which the AGC has initiated formal proceedings.

The AGC does not have primary jurisdiction over the Michigan Judiciary. Complaints regarding Michigan judges should be sent to the Judicial Tenure Commission at:

The Judicial Tenure Commission, 3034 West Grand Boulevard, Suite 8-450, Detroit, MI 48202

How to File a Request for Investigation

Anyone may file a Request for Investigation against an attorney licensed by the State Bar of Michigan, or otherwise permitted by a court to practice in the state, by completing and signing the AGC's Request for Investigation form or by sending in a signed letter. THE FORM OR LETTER MUST BE SIGNED AND SUFFICIENTLY DESCRIBE THE ALLEGED MISCONDUCT (INCLUDING APPROXIMATE TIME AND PLACE). The Request for Investigation may include copies of any relevant documents or transcripts. A Request for Investigation must contain an original signature therefore, Requests for Investigation are not accepted electronically or by facsimile.

A copy of the Request for Investigation form can be requested by calling the AGC at (313) 961-6585, or can be downloaded by clicking here. Requests for Investigation and any accompanying documents can be sent to:

Michigan Attorney Grievance Commission, 243 W. Congress, Ste. 256, Detroit, MI 48226

The Grievance Administrator may also institute an investigation on his own based upon knowledge gained from other ways, such as news articles, court opinions, or information received in the course of a disciplinary investigation.

http://www.agcmi.com/

State of Michigan

Attorney Grievance Commission

243 West Congress, Suite 256

Detroit MI 48226-3259

REQUEST FOR INVESTIGATION (R/I) FORM

Please fill out the entire form – sign at the bottom – and provide a copy of any relevant information.

Attorney information:

Name (one attorney per R/I form):		
Address (number and street):		
City:	State:	Zip Code:
Area code and Telephone Number:	Date attorney was hired/appointed:	
Type of case (divorce, criminal, estate, etc):		
Name of court:		Case #:
Is this your first complaint to this office about this attorney?	Date of previous complaint (if applicable):	

STATEMENT OF FACTS

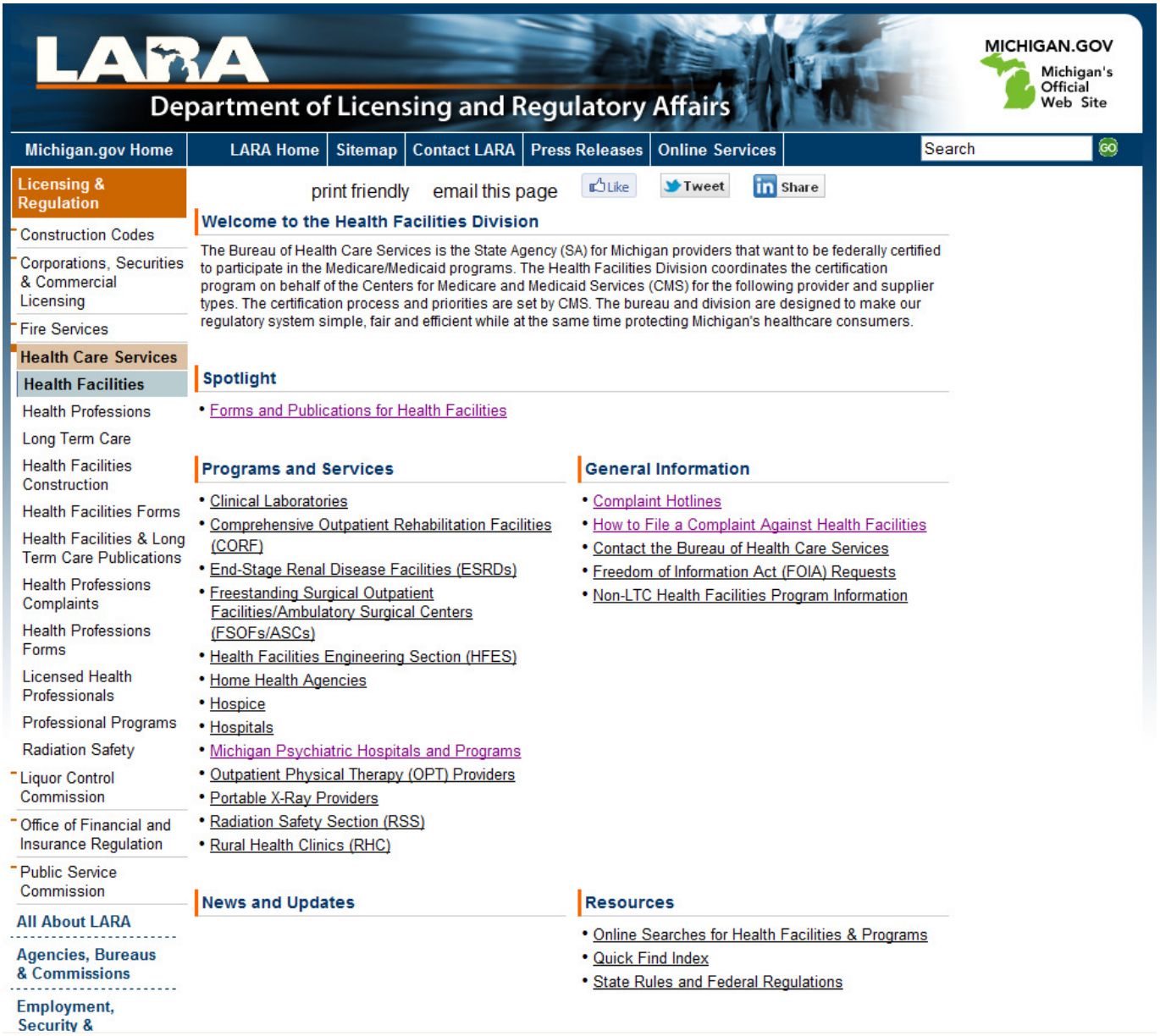
(Please provide details. You may attach additional pages.)

I request the Attorney Grievance Commission investigate the above attorney:

Name – type or print:		
Signature:		Date:
Address (number and street):		
City:	State:	Zip Code:
Area code and Telephone number:		

For Complaints against a Health Care Facility:

http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63302---,00.html



Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Community and Health Systems
611 W. Ottawa Street, P. O. Box 30664
Lansing, MI 48909

HEALTH FACILITY COMPLAINT FORM

Please print clearly or type information on all sections of this form. If you need help or have questions about this form, please call 1-800-882-6006.

INFORMATION ABOUT PERSON FILING THE COMPLAINT

If you wish to remain anonymous, do not complete this section. If anonymous, our office will not be able to contact you to obtain additional information or notify you of the results of the investigation.

Your Name	**Daytime Phone #** ( ) - ☐ Work	**Evening Phone #** ( ) - ☐ Work	
Street Address	**City**	**State**	**Zip Code**
E-mail Address (that the department can use to contact you if more information is needed)			

RESIDENT/PATIENT INFORMATION

Resident/Patient Name		**Birthdate and/or Age** / /	
Date Admitted/Entered / /	**Room # (if applicable)**	**Date Discharge/Left (if applicable)** / /	
Guardian or Resident/Patient Representative	**Daytime Phone #** ( ) -	**Evening Phone #** ( ) -	

FACILITY/AGENCY INFORMATION

- ☐ Nursing home/long term care facility
- ☐ Hospital/Long Term Care Unit
- ☐ Hospital (including psychiatric)
- ☐ Surgery center
- ☐ Hospice agency or residence
- ☐ Home health agency
- ☐ Other*

* Other federally certified providers include dialysis centers, rural health clinics, outpatient physical therapy (OPT) providers, comprehensive outpatient rehab facilities (CORF), portable X-ray providers, and providers offering laboratory services.

Facility/Agency Name			
Facility/Agency Street Address	**City**	**State** MI	**Zip Code**

INFORMATION ABOUT YOUR COMPLAINT					
Date of Problem/Incident / /	**Time** :	☐	**AM**	☐	**PM**

The Department will not disclose the name of a complainant or resident/patient during an investigation without written consent. However, the investigation can proceed quicker if the complaint can be discussed at the time of the investigation.

Do you give permission for the resident/patient's name to be released?	☐ **Yes**	☐ **No**

What is the complaint about?
Attach additional sheets if necessary. No. of additional pages attached: ( )

Have you contacted the facility/agency about your complaint?	**Yes** ☐	**No** ☐	**If yes, name of the person you talked with?**
Your Signature:			**Date Signed:**

All Health Care Facilities that are state licensed and/or federally certified providers are required to post the name, title, location, and telephone number of staff responsible for receiving complaints. You may wish to contact the provider representative or administrator before filing this complaint.

The Department will send an acknowledgement letter upon receipt of the complaint and will send an additional letter after the investigation is completed to notify the complainant regarding the results of the investigation. You may submit the completed signed form to the Bureau of Community and Health Systems by mail, email or FAX to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems – Health Facility Complaints
P.O. Box 30664
Lansing, MI 48909
FAX (517) 241-0093
BHCS-Facility-Complaints@michigan.gov www.michigan.gov/lara

Other agencies that help citizens with complaints are:

For complaints related to a **state licensed child care center, adult foster care facility or adult/child camp**, please visit our online complaint page for these additional covered providers.

The State Long-Term Care Ombudsman
The ombudsman investigates complaints at licensed long-term care facilities.
Call: 1-866-485-9393 (toll-free) or find more information at http://www.elderslaw.org

Department of Attorney General (AG)
The AG investigates elder abuse and Medicaid fraud.
Call: 1-800-242-2873 or find more information at www.michigan.gov/ag

Michigan Protection & Advocacy Service (MPAS)
MPAS can help you file a complaint or investigate an abuse/neglect allegation.
Call: 1-800-288-5923 or (517) 487-1755 or find more information at www.mpas.org

Citizens for Better Care (CBC)
CBC is an advocacy group for nursing home residents and families.
Call: Detroit 1-800-833-9548 or find more information at www.cbcmi.org

Bureau of Professional Licensing (BPL)
BPL handles complaints against licensed professionals including physicians, nurses, etc.
Find more information at www.michigan.gov/bpl

Michigan Department of Health and Human Services (MDDHS)
DHHS handles abuse and neglect complaints. Find more information at www.michigan.gov/mdhhs.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc. under the Americans with Disability Act, you may make your needs known to this agency.

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH PROFESSIONS
RAE RAMSDELL
DIRECTOR

STEVE HILFINGER
DIRECTOR

Enclosed is the allegation form you requested.

Also enclosed are two (2) "Authorization For Release of Privileged/Client Information" forms for signature by the patient, his/her representative, or guardian, if the patient is a minor. **A sample release form is enclosed to assist you. Additionally, carefully read the following instructions to assist you in accurately filling out the forms:**

- Include the patient's date of birth and last 4 digits of their social security number, if applicable.
- Make sure the patient and his/her representative, or guardian signs and dates the form.
- Mail originals of ALL forms. Do not fax forms.
- If you are signing this release on behalf of a patient, who is not a minor child, you must provide us with a Letter of Authority, issued by the probate court, which empowers you to act on behalf of the patient.
- Do not include information for more than one doctor or hospital on the same release form. Doing so will make the form invalid.
- Do not make any additional markings and/or comments on the release form other than the information required. Doing so will make the form invalid.

Additionally, enclosed is a "Treatment Data" form (you may keep the yellow copy of the form for your records), the "Authorization for Release of Privileged/Client Information" form and the "Treatment Data" form. Upon receipt of the completed documents, your allegation will be reviewed and a determination will be made if licensing action should be considered.

If you have any questions in completing the enclosed forms, or if you need additional forms, please contact our office at the phone number listed below.

Health Investigation Division
Bureau of Health Professions
Telephone: (517) 373-9196

For Complaints Against a Health Care Professional

http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303---,00.html

LARA/HID-200 (5/11)

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Professions
Health Investigation Division
P.O. Box 30454
Lansing, MI 48909-9897
(517) 373-9196

Office Use Only
File #:

ALLEGATION FORM

Authority: Public Act 368 of 1978, as amended
Completion: Voluntary Penalty: None

I wish to complain against the individual named below. **I understand that this agency and the Licensing Board DO NOT assist citizens seeking reimbursement or resolution of billing and fee disputes**.

INSTRUCTIONS: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the white copy to the address above. Retain the canary copy for your records. Please complete a separate form for each practitioner you are filing an allegation against. **Please be advised that this agency DOES NOT investigate anonymous allegations.**

Information About You		
Your Name		
Street Address		
City		
State	Zip Code	Country
Patient's Name		
Patient's Date of Birth (MM/DD/YYYY)		
Patient's Last 4 Digits of Their Social Security Number		
Your Telephone Numbers With Area Code Cell: ( ) Home: ( ) Work: ( )		

Allegation Being Filed Against	
Practitioner's First and Last Name	
Street Address	
City	
State	Zip Code
Practitioner's Telephone Number ( )	
Treatment/Incident Date	

Check the profession for which you are lodging an allegation about:

- ☐ Acupuncture
- ☐ Allopathic Physician (MD)
- ☐ Athletic Trainer
- ☐ Audiologist
- ☐ Chiropractor
- ☐ Counselor
- ☐ Dentistry
- ☐ Dietitian or Nutritionist
- ☐ Marriage & Family Therapist
- ☐ Massage Therapist
- ☐ Nurse (RN or LPN)
- ☐ Nursing Home Administrator
- ☐ Nurse Aide (CNA)
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Osteopathic Physician (DO)
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physician's Assistant
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Respiratory Therapist
- ☐ Sanitarian
- ☐ Social Worker
- ☐ Speech/Language Pathologist
- ☐ Veterinarian

Is there civil actions pending?	Is there a police report?	May we release your name and this information to the practitioner?	Will you testify at an Administrative Hearing if necessary?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details of your specific concerns related to the treatment rendered. Attach additional sheets if necessary.

Your Signature	**Date**

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

LARA/HID-201 (5/11)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Health Professions – Investigation Division

Office Use Only
FILE NUMBER:
~ SAMPLE ~

TREATMENT DATA FORM

NAME OF PATIENT: SMITH (LAST) MARY (FIRST) P. (M.I.)

Date of Birth: 01/01/1950 **Last 4 digits of Social Security Number:** 6780

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: JOHN DOE, M.D. **Dates of Treatment:**

ADDRESS: 123 MAIN STREET **Beginning:** MAY 2010

CITY/STATE/ZIP: LANSING, MI 48910 **Ending:** SEPTEMBER 2010

TELEPHONE: (517) 361-5858

FULL NAME: GOOD SAMARITAN HOSP. **Dates of Treatment:**

ADDRESS: 789 FIRST STREET **Beginning:** AUGUST 24, 2010

CITY/STATE/ZIP: LANSING, MI 48912 **Ending:** AUGUST 31, 2010

TELEPHONE: (517) 361-5676

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: _____

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: _____

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

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

LARA/HID-201 (5/11)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Health Professions – Investigation Division

Office Use Only
FILE NUMBER:

TREATMENT DATA FORM

NAME OF PATIENT: ____
LAST FIRST M.I.

Date of Birth: __________________ **Last 4 digits of Social Security Number:** ___ ______ ___

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: _____________________________ **Dates of Treatment:**

ADDRESS: _____________________________ **Beginning:** ______________________

CITY/STATE/ZIP: _________________________ **Ending:** ______________________

TELEPHONE: _____________________________

FULL NAME: _____________________________ **Dates of Treatment:**

ADDRESS: _____________________________ **Beginning:** ______________________

CITY/STATE/ZIP: _________________________ **Ending:** ______________________

TELEPHONE: _____________________________

FULL NAME: _____________________________ **Dates of Treatment:**

ADDRESS: _____________________________ **Beginning:** ______________________

CITY/STATE/ZIP: _________________________ **Ending:** ______________________

TELEPHONE: _____________________________

FULL NAME: _____________________________ **Dates of Treatment:**

ADDRESS: _____________________________ **Beginning:** ______________________

CITY/STATE/ZIP: _________________________ **Ending:** ______________________

TELEPHONE: _____________________________

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

LARA/HID-202 (5/11)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Health Professions
Health Investigation Division
P.O. Box 30454
Lansing, MI 48909-9897

Office Use Only
FILE NUMBER: **~ SAMPLE~**

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, MARY SMITH, hereby authorize JOHN DOE, M.D.
(Patient/Client/Representative's Name) (Doctor/hospital/program or other custodian of record name)

1234 Main Street, Lansing MI 48910
(Address of doctor/hospital/program or other custodian of records)

To release/exchange information contained in the records of:

MARY SMITH	01/01/1950	6789
Patient's Name	Date of Birth	Last 4 digits of Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made**:
Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Health Professions, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, Michigan 48911 or the Department of Attorney General.

2. **Specific type of information to be disclosed**:
Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).

3. **The purpose and need for such disclosure**:
I understand that the Department of Licensing and Regulatory Affairs, Bureau of Health Professions and/or the Department of Attorney General may use any information and records so released in connection with the administration and enforcement of the laws of this State and of the United States.

4. I understand that if I give LARA permission I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Office, Michigan Department of Licensing and Regulatory Affairs, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, MI 48911. I also understand that LARA cannot take back any uses or disclosures already made with my permission. Unless otherwise revoked or if I fail to specify an expiration date, event or condition, this authorization will expire ONE (1) year from the signature date.

5. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

A copy of this authorization shall serve in the stead of the original.

Mary Smith — 3/24/2011
Patient/Client or Representative's Signature — **Date Signed**
(If signed by a Legal Representative, relationship to the Patient/Client. A letter of authority may be required)

Tim Smith — 3/24/2011
Witness' Signature — **Date Witnessed**

3/24/2011
Date Prepared

This authorization is acceptable to the Michigan Department of Licensing and Regulatory Affairs as compliant with HIPAA privacy regulations, 45 CFR, Parts 160 & 164, as modified December 11, 2003. If you need assistance with reading, writing, hearing, etc., under the American's with Disability Act, you may make your needs known to this Agency.

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

LARA/HID-202 (5/11)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Health Professions
Health Investigation Division
P.O. Box 30454
Lansing, MI 48909-9897

Office Use Only
FILE NUMBER:

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, _____, hereby authorize _____
(Patient/Client/Representative's Name) (Doctor/hospital/program or other custodian of record name)

_____
(Address of doctor/hospital/program or other custodian of records)

To release/exchange information contained in the records of:

_____
Patient's Name Date of Birth Last 4 digits of Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made**:
   Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Health Professions, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, Michigan 48911 or the Department of Attorney General.

2. **Specific type of information to be disclosed**:
   Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).

3. **The purpose and need for such disclosure**:
   I understand that the Department of Licensing and Regulatory Affairs, Bureau of Health Professions and/or the Department of Attorney General may use any information and records so released in connection with the administration and enforcement of the laws of this State and of the United States.

4. I understand that if I give LARA permission I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Office, Michigan Department of Licensing and Regulatory Affairs, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, MI 48911. I also understand that LARA cannot take back any uses or disclosures already made with my permission. Unless otherwise revoked or if I fail to specify an expiration date, event or condition, this authorization will expire ONE (1) year from the signature date.

5. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

A copy of this authorization shall serve in the stead of the original.

_____ _____
Patient/Client or Representative's Signature **Date Signed**
(If signed by a Legal Representative, relationship to the Patient/Client.
A letter of authority may be required)

_____ _____
Witness' Signature **Date Witnessed**

_____
Date Prepared

This authorization is acceptable to the Michigan Department of Licensing and Regulatory Affairs as compliant with HIPAA privacy regulations, 45 CFR, Parts 160 & 164, as modified December 11, 2003. If you need assistance with reading, writing, hearing, etc., under the American's with Disability Act, you may make your needs known to this Agency.

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

Michigan Department of Licensing and Regulatory Affairs
BUREAU OF HEALTH CARE SERVICES
FACILITY COMPLAINT AND INVESTIGATION SECTION
COMPLAINT INVESTIGATION UNIT

RESIDENT/PATIENT CARE COMPLAINT FORM

Print clearly or type information on all sections of this form. Call 1-800-882-6006 if you need help completing the form.

RESIDENT INFORMATION											
Resident/Patient Name							**Birthdate**				
Date Admitted		**Room #**		**Discharge Date (if no longer in facility)**							
Guardian/Resident Representative				**Daytime/Work Phone #**			**Evening Phone #**				
FACILITY INFORMATION (Check Type)											
	ASC		**EMS**		**FS-ASC**		**HOSP**		**OPT**		**RS**
	CMCF		**ESRD**		**HHA**		**HSPC**		**PSYCH HOSP**		**X-RAY**
	CORF		**FSOF**		**HLTU**		**NH**		**RHC**		
Facility Name											
Facility Street Address			**City**		**State** MI		**Zip Code**				
INFORMATION ABOUT PERSON FILING THE COMPLAINT											
Your Name (if not resident)				**Daytime/Work Phone #**			**Evening Phone #**				
Street Address				**City**			**State**	**Zip Code**			
Contact Person (if different)				**Daytime/Work Phone #**			**Evening Phone #**				
E-mail Address											
INFORMATION ABOUT YOUR COMPLAINT											
Date of problem or incident:			**Time**			**AM**		**PM**			

The Department will not disclose the name of a complainant or the resident named in the complaint during a nursing home investigation without written consent. However, the investigation can proceed more quickly if the complaint can be discussed at the time of the investigation.		
Do you give permission for the resident's name to be released to discuss the complaint?	**Yes**	**No**

What is the complaint about? Attach additional sheets if necessary. **No. of pages attached: ( )**

Have you contacted the facility about your complaint?	**Yes**	**No**	**If yes, person's name and title?**
Your Signature:			**Date Signed:**

All nursing homes are required to post the name, title, location, and telephone number of an individual in the nursing home who is responsible for receiving complaints and conducting complaint investigations. Someone in the nursing home should be on duty 24 hours a day, 7 days a week to respond to complaints. You may wish to contact the facility representative or administrator before filing this complaint.

You may complete and sign this form, and submit it to the Bureau of Health Care Services by mail or fax to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Systems, Complaint Investigation Unit
P.O. Box 30664, Lansing, MI 48909
Fax # (517) 241-0093 http://www.michigan.gov/bhcs

Other agencies that help citizens with complaints are:

The State Long-Term Care Ombudsman
State long-term care ombudsman will help identify, investigate and help resolve complaints of residents of licensed long-term care facilities through its network of local ombudsmen.
Call: 1-866-485-9393 (toll-free)
http://www.elderslaw.org/

Department of Attorney General (AG)
The Attorney General investigates elder abuse and Medicaid fraud.
Call: 1-800-242-2873 or file a complaint online at
http://www.michigan.gov/ag/

Michigan Protection & Advocacy Service (MPAS)
MPAS can tell you who you should call to report abuse/neglect, help you file a complaint, or investigate an abuse/neglect allegation.
Call: 1-800-288-5923 or (517) 487-1755
http://www.mpas.org/

Citizens for Better Care (CBC)
CBC is an advocacy group for nursing home residents and families.
Call: Detroit 1-800-833-9548
http://www.cbcmi.org

BUREAU OF COMMUNITY AND HEALTH SYSTEMS
CHILD CARE LICENSING DIVISION
ADULT FOSTER CARE AND CAMPS DIVISION
COMPLAINT FORM

The Bureau of Community and Health Systems, Child Care Licensing Division and Adult Foster Care and Camps Division receive and process complaints for:

- Adult Foster Care and Homes for the Aged.
- Child Care Facilities.
- Children's Camps.
- Adult Foster Care Camps.

Nursing Homes – To make a complaint against a nursing home, go to http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63302-64503--,00.html or call (800) 882-6006.

When making a complaint, it is important that you fill out the complaint form as completely as possible. Your name will be kept **confidential** and **will not** be released unless ordered by the court. You are not required to give your name or contact information. However, if you do not provide it, a licensing consultant will not be able to contact you if additional information is needed. **Your complaint may not be assigned or may be unconfirmed due to an inability to reach you for follow-up.**

Abuse and/or Neglect Complaints

Call 855-444-3911 if you are making a complaint regarding abuse, neglect or exploitation:

- In a child care facility (family or group child care home or child care center).
- Of an adult.

Complete the online complaint form below to make a complaint regarding abuse or neglect of a child in a children's camp or an adult in an adult foster care camp.

Learn more about abuse and neglect.

Unlicensed Complaints

If you are making a complaint regarding a facility/agency/provider operating without a registration/license, you must indicate how you know the facility/agency/provider is operating without a registration/license.

Complaint Information

I wish to complain against the facility/agency/provider named below. I am submitting this information so that it may be determined if a licensing action against this facility/agency/provider should be considered.

Information About You				Complaint Against		
Your Name				Facility/Agency/Provider		
Street Address				Registration/License # (if known)		
City				Street Address		
State	Zip Code	County		City	State	Zip Code
Email address				Telephone Number ( )		
Your Telephone Number Home: ( )		Work: ( )		Incident Date (if applicable)		
Your Role/Relationship to the Facility/Agency/Provider (E.g., Parent of Child in Care, Employee, Centralized Intake, etc.)						
Check One: ☐ Adult Foster Care Facility ☐ Home for the Aged		☐ Child Care Home ☐ Child Care Center		☐ Children's Camp ☐ Adult Foster Care Camp		
I certify that the information provided is complete and accurate to the best of my knowledge. I understand that making a false complaint is a crime punishable by up to a $5,000 fine, imprisonment for up to four years, or both.						
Signature				Date		

Authority:
P.A. 116 of 1973, as amended, P.A. 368 of 1978, as amended,
P.A. 218 of 1979, as amended

Complaint Form (7-15)

Is this a complaint regarding a facility/agency/provider operating without a registration/license? ☐ No ☐ Yes
If yes, how do you know the facility/agency/provider is operating without a registration/license?

For all other complaints or an unlicensed complaint where you have additional concerns, answer the following questions, as applicable, regarding each concern. Be as specific as possible.
(Use additional sheets if necessary.)

Who was involved? (If you know the names of caregivers/employees/residents/children involved, provide them.)

What happened?

When did it happen? (Particular day, time of day, etc.)

How many times did this happen?

Where did it take place? (Specific area/room of the facility, off-site, etc.)

Did other people see it? Do other people know about it? If yes, include their names.

How do you know this happened? Or about the violation?

Is it still going on? If yes, how do you know?

If you know the act section or rule violated or the contract, provide it.

Authority:
P.A. 116 of 1973, as amended, P.A. 368 of 1978, as amended,
P.A. 218 of 1979, as amended
Complaint Form (7-15)

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Health Facilities Division
Substance Abuse Program
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

LARA/SUB- 504 (5/13)

RECIPIENT RIGHTS COMPLAINT FORM

Authority: Public Act 368 of 1978, as amended

To Be Completed By Rights Advisor:

Program Name
License Number
Complaint Number
Date Received by Rights Advisor
Date Report Due to Recipient

1. **DESCRIBE YOUR COMPLAINT:** (Does your complaint involve a person, a procedure, or the building the program is in? Give names of witnesses or other details that will help your rights advisor understand your complaint). Attach additional paper if necessary.

_____

_____

_____

_____

2. **Where did it happen?** (Address or Location): _____

_____

3. **When did it happen?** (Date (MM/DD/YY) and Time) _____

4. **What right(s) do you think were violated?** _____

_____

_____

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

_____

6. **How do you want to get your copy of the investigation report on this complaint?** (Check one)

☐ **PICK UP** in rights' advisor's office with 30 working days. When report is ready, please call me at:
_____ _____ (Telephone Number w/area code)

☐ **MAIL** to me at the following address by registered mail:

_____ _____ _____ _____
Street Address City State Zip Code

Recipient's Signature (must also sign authorization to release information on Page 2).

Signature: _____ Date: _____

Rights Advisor's Signature: _____

Printed Name: _____ Date: _____

Copies to: 1) Program 2) LARA/BHCS/SUBSTANCE ABUSE 3) Coordinating Agency

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services – Health Facilities Division
Substance Abuse Program
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

INSTRUCTIONS FOR THE RECIPIENT/CLIENT
RECIPIENT RIGHTS COMPLAINT FORM

HOW TO FILE A COMPLAINT

A. You should fill out the attached form if you believe one of your rights has been violated.
B. If you need help to write out your complaint, please see your rights advisor.
C. If you are not sure what right was violated, ask your rights advisor for a list of your rights.
D. After you fill out items 1 through 7 on Page 1, sign the authorization to release information form.
E. Give the form to your rights advisor.

WHAT WILL HAPPEN

After you give the completed form to your rights advisor, he or she may ask you for additional information. The rights advisor will then investigate your complaint and try to develop a fair solution.

Within 30 working days of the date your rights advisor receives this form, he or she will give you a written **Recipient Rights Investigation Report**. That report will have a summary of what the rights advisor found while investigating your complaint. It will have a proposed solution (action plan) if your complaint was found to require action.

YOUR RIGHT TO APPEAL

When you receive the *Recipient Rights Investigation Report*, you will have **15** working days to decide to accept the findings and/or action plan proposed by the program, or to file an appeal. If you do not appeal within **15** working days, this indicates/means you have accepted the investigation report.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the _____
Program to release information contained in my program records to my coordinating agency rights consultant or designee and to the substance abuse rights coordinator or designee. I authorize release of information that is necessary for the complete investigation of my recipient rights complaint and any future appeals. The release includes authorization to interview witnesses concerning my complaint when such interviews are necessary for a complete investigation of my complaint.

This authorization is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished.

Without expressed revocation, this authorization expires when the investigation of my complaint or subsequent appeals has been completed.

_____ _____
Signature of Recipient Date Signed

_____ _____
Signature of Witness Date Witnessed

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans With Disabilities Act, you may make your needs known to this agency.

IT'S GOOD TO KNOW ABOUT YOUR

RIGHTS

IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS WHEN YOU GET SUBSTANCE ABUSE SERVICES,

WE CAN HELP

PROGRAM RIGHTS ADVISOR	REGIONAL RIGHTS CONSULTANT

Recipient Rights Coordinator
Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Health Facilities Division
Substance Abuse Licensing Section
P.O. Box 30664, Lansing, MI 48909

RIGHTS OF RECIPIENTS OF SUBSTANCE ABUSE SERVICES

1978 Public Act 368 and Promulgated Rules

Recipient rights generally.

(1) A recipient shall not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual preference, or political beliefs.

(2) The admission of a recipient to a treatment program or receipt of prevention services shall not result in the recipient being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitutions.

(3) A recipient may present grievances or suggest changes in program policies and services to the program staff, to governmental officials, or to another person within or outside the program. In this process, the program shall not in any way restrain the recipient.

(4) A recipient has the right to review, copy, or receive a summary of his or her program records, unless, in the judgment of the program director, such action will be detrimental to the recipient or to others for either of the following reasons:

(a) Granting the request for disclosure will cause substantial harm to the relationship between the recipient and the program or to the program's capacity to provide services in general.

(b) Granting the request for disclosure will cause substantial harm to the recipient.

If the program director determines that such action will be detrimental, the recipient is allowed to review nondetrimental portions of the record or a summary of the nondetrimental portions of the record. If a recipient is denied the right to review all or part of his or her record, the reason for the denial shall be stated to the recipient. An explanation of what portions of the record are detrimental and for what reasons, shall be stated in the client record and shall be signed by the program director.

(5) A program staff member shall not physically or mentally abuse or neglect or sexually abuse a recipient.

(6) A recipient has the right to review a written fee schedule in programs where recipients are charged for services. Policies on fees and any revisions thereto shall be approved by the governing authority of the program and shall be recorded in the administrative record of the program.

(7) A recipient is entitled to receive an explanation of his or her bill, regardless of the source of payment.

(8) A recipient has the right to information concerning any experimental or research procedure proposed as part of his or her treatment or prevention services and has the right to refuse to participate in the experiment or research without jeopardizing his or her continuing services. A program shall comply with state and federal rules and regulations concerning research which involves human subjects.

Treatment programs; specific rights;

(1) A recipient shall participate in the development of his or her treatment plan.

(2) A recipient has the right to refuse treatment and to be informed of the consequences of that refusal. When a refusal of treatment prevents a program from providing services according to ethical and professional standards, the relationship with the recipient may be terminated upon reasonable notice.

(3) A recipient shall be informed if a program has a policy for discharging recipients who fail to comply with program rules and shall receive, at admission and thereafter upon request, a notification form that includes written procedures which explain all of the following:

(a) The types of infractions that can lead to discharge.

(b) Who has the authority to discharge recipients.

(c) How and in what situations prior notification is to be given to the recipient who is being considered for discharge.

(d) The mechanism for review or appeal of a discharge decision.

A copy of the notification form signed by the recipient shall be maintained in the recipient's case file.

(4) A recipient shall have the benefits, side effects, and risks associated with the use of any drugs fully explained in language which is understood by the recipient.

(5) A recipient has the right to give prior informed consent, consistent with federal confidentiality regulations, for the use and future disposition of products of special observation and audiovisual techniques, such as 1-way vision mirrors, tape recorders, television, movies, or photographs.

(6) Fingerprints may be taken and used in connection with treatment or research or to determine the name of a recipient only if expressed written consent has been obtained from the recipient. Fingerprints shall be kept as a separate part of the recipient's records and shall be destroyed or returned to the recipient when the fingerprints are no longer essential to treatment or research.

Inpatient and residential programs; specific rights.

(1) A recipient has the right to associate and have private communications and consultations with his or her physician and attorney.

(2) A program shall post its policy concerning visitors in a public place.

(3) Unless contraindicated by program policy or individual treatment plan, a recipient is allowed visits from family members, friends, and other persons of his or her choice at reasonable times, as determined by the program director or according to posted visitors' hours. A recipient shall be informed in writing of visitors' hours upon admission to the program.

(4) To protect the privacy of all other recipients, a program director shall ensure, to the extent reasonable and possible, that the visitors of recipients will only see or have contact with the individual they have reason to visit.

(5) A recipient has the right to be free from physical and chemical restraints, except those authorized in writing by a physician for a specified and limited time. Written policies and procedures which set forth the circumstances that require the use of restraints and which designate the program personnel responsible for applying restraints shall be approved in writing by a physician and shall be adopted by the program governing authority. Restraints may be applied in an emergency to protect the recipient from injury to self or others. The restraint shall be applied by designated staff. Such action shall be reported to a physician immediately and shall be reduced to writing in the client record within 24 hours.

(6) A recipient has the right to be free from doing work which the program would otherwise employ someone else to do, unless the work and the rationale for its therapeutic benefit are included in program policy or in the treatment plan for the recipient.

(7) A recipient has the right to a reasonable amount of personal storage space for clothing and other personal property. All such items shall be returned upon discharge.

(8) A recipient has the right to deposit money, earnings, or income in his or her name in an account with a commercial financial institution. A recipient has the right to get money from the account and to spend it or use it as he or she chooses, unless restricted by program policy or by the treatment plan for the recipient. A recipient has the right to receive all money or other belongings held for him or her by the program within 24 hours of discharge.

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

Bureau of Health Care Services
Health Facilities Division
State Licensing Section
Substance Abuse Programs

SUMMARY OF FEDERAL CONFIDENTIALITY REGULATIONS

APPLICABILITY

The revised regulations went into effect on August 10, 1987 and apply to all state licensed substance abuse programs.

RECORDS AND INFORMATION COVERED

1. Records of Identity.
2. Records of Prognosis.
3. Records of Diagnosis.
4. Treatment Records.
5. Attendance Records.
6. Patient Status Records.
7. Physical Whereabouts Records.

The above covered information may be released only by written consent signed by the client. Written consent must include:

1. Name or general description of the program(s) which are to make the disclosure.
2. The name of the person or organization which shall receive the information.
3. Why the information is needed.
4. The extent or nature of the information to be disclosed.
5. The client's name.
6. A statement that the consent may be withdrawn at any time, except to the extent that the program that is to make the disclosure has already taken action in reliance on the consent.
7. A date, event or condition on which the consent will expire unless revoked earlier by the client.
8. Signature of the client.
9. The date of the client's signature.

See the SAMPLE SECTION for proper release forms to be used by licensed substance abuse programs.

DISCLOSURES NOT CONSIDERED CONFIDENTIAL

1. Communications between staff members of a program.

2. Communications between a program and its governing authority.

3. Communications between a program and a "Qualified Service Organization." For further definition of a "Qualified Service Organization," review section 2.11(a), page 21806 of the Federal Regulations.

4. Information which contains no "patient identifying information." For definition of "patient identifying information," review section 2.11, page 21806 of the Federal Register.

TYPES OF INFORMATION WHICH MAY BE DISCLOSED WITH CONSENT

A program should only disclose information about a client which is actually needed for the purpose stated on the signed consent form. Listed below are some general rules to go by:

1. A treatment program, by signed consent, can provide information necessary for treatment, diagnosis or rehabilitation.

2. An attorney may receive any information dealing with a legal matter in accordance with the client's written consent.

3. Family and friends may receive, with written consent, information about the client's status and progress.

4. Third party payers or funding sources may receive information reasonably needed to process the client's claim, upon receipt of a signed consent.

There are specific rules for disclosure to the criminal justice system. Section 2.35 of the regulations should be reviewed for further details.

DISCLOSURES WITHOUT CLIENT CONSENT

1. Patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention. The program must document the nature, extent and reason for the disclosure in the client's file. For further discussion, review section 2.51(c) of the Federal Regulations.

2. Client identifying information may be disclosed for the purpose of conducting scientific research. For further details, review section 2.52 of the Federal Regulations.

3. If client records are not copied or removed, client identifying information may be disclosed without the consent of the client for the purposes of audit or evaluation activities. The procedure described in section 2.53 of the Federal Regulations is to be followed.

CLARIFICATIONS

1. These regulations apply specifically to programs that specialize in whole or part, in providing alcohol or drug abuse treatment or diagnosis and referral services. (Section 2.11.)

2. Programs can disclose that a particular individual is not and never has been a client. (Section 2.13(c)(2))

3. Program staff may disclose information without the written consent of a client to other staff within a program or to the governing authority if the receiver of the information needs it in connection with duties that arise out of the provision of alcohol or drug abuse diagnosis, treatment or referral services. (Section 2.12(c)(3))

4. These regulations eliminate any restrictions on compliance with state laws mandating the reporting of suspected child abuse or neglect.

5. Programs are required to give clients a written summary of the confidentiality law and regulations. This notice must be given to clients at the time of their admission to the program. (Section 2.22)

6. Programs have the discretion as to whether a client should view or obtain copies of their own records. (Section 2.23)

SAMPLE

CLIENT NOTICE OF CONFIDENTIALITY

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

(1) The patient consents in writing:
(2) The disclosure is allowed by a court order; or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Law and Regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal Laws and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local authorities.

SAMPLE

NOTICE TO ACCOMPANY DISCLOSURE

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 7

SAMPLE

CLIENT INFORMATION RELEASE AUTHORIZATION

I, _____ , hereby authorize _____ _____, to release
(Client's Name) (Name or General Designation of Program)

information contained in my client records to the individuals or organizations and only under the conditions listed below:

1. Name or title of person or organization to whom disclosure is made: _____ _____

2. Specific type of information to be disclosed: _____ _____

3. The purpose or need for such disclosure: _____ _____

4. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

   A. Date: _____

   B. Event: _____

   OR

   C. Condition: _____

_____ _____ _____
WITNESSED BY CLIENT'S SIGNATURE

_____ _____ _____
DATE WITNESSED DATE SIGNED

SAMPLE FORM

TO BE USED BY LICENSED PROGRAMS
For Use in Criminal Justice System

I,_____ , hereby consent to communication between _____

_____ and _____.

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance at treatment sessions, my cooperation with the treatment program, prognosis, and _____

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____ _____
(Other times when consent can be revoked.)

_____ _____
(Other expiration of consent.)

I also understand that any disclosures made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

_____ _____
(Date) (Client's Signature)

_____
(Witness' Signature)

SAMPLE LETTER IN RESPONSE TO A SUBPOENA

One of the most frequent questions treatment programs ask is, "How do we respond to a subpoena demanding client records or staff members' testimony about a client?" The short answer is: ***Do not ignore the subpoena!*** *Instead, explain why the program cannot turn over records or testify unless the person alleged to be a client signs a proper consent or a proper court order is issued first. Here is a sample letter that treatment programs can use to respond to a subpoena, and explain the applicable rules, in a civil (not a criminal) proceeding:*

Dear _____,

We have received your subpoena requesting [any records] [testimony from program personnel] concerning [name of patient]. Federal confidentiality laws and regulations (see 42 U.S.C. §§ 290dd-2, 42 C.F.R. Part 2) prohibit this program and its personnel from complying with your request or even acknowledging whether or not this individual is or ever was a patient in our program unless [he/she] executes a proper consent form or the court issues an order authorizing disclosure in accordance with Subpart E of the federal confidentiality regulations (42 C.F.R. § 2.13).

The federal confidentiality laws and regulations permit the release of information about current or former patients with written patient consent in a particular form specified in the regulations. (See 42 C.F.R. § 2.31.) A general medical release is not sufficient.

The federal law and regulations prohibit a program from disclosing information in response to a subpoena (even a judicial subpoena) unless the subpoena is accompanied by a proper consent or a court issues an order in compliance with the procedures and standards set forth in Subpart E of the regulations, §§ 2.61-2.67.

Subpart E of the regulations provides that before the court may issue an order authorizing a program to release patient information, both the alleged patient (or his/her representative) and the program must be notified that a hearing will be held to decide whether an authorizing court order will be issued, and both the patient and the program must be given an opportunity to appear in person or file a responsive statement (42 C.F.R. § 2.64(b)).

In order to issue an authorizing order the court must find, at or after the required hearing, that "good cause" exists to issue the order (§ 2.64(d)). The regulations provide that

> to make this [good cause] determination the court must find that:
>
> (1) Other ways of obtaining the information are not available or would not be effective; and
>
> (2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

The federal regulations also limit the type of material that a court may order a program to release. Section 2.64(e) provides that an order must "limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order" and that only those persons having a need for the information may receive patient records. Section 2.63 provides that a court may not order any disclosure of confidential communications made by a patient to program staff unless one of three additional conditions is met: (1) the disclosure is necessary to protect against an existing threat to life or of serious bodily injury, (2) the disclosure is necessary in connection with investigation or prosecution of a very serious crime, such as homicide or rape, or (3) the patient has already offered evidence about confidential communications.

Thus, for the court to issue an authorizing court order permitting program personnel to release records containing confidential communications by a patient or to testify about any communications made by a patient, it would first have to find

1. that there is no other way to obtain the necessary information, or other ways would be ineffective;

2. disclosure would not harm the public interest in attracting people to substance abuse treatment; and

3. that one of the three specific conditions of § 2.63 has been met.

Since this program has not received a proper written consent form from the individual about whom [records/testimony] [is/are] sought, or an authorizing court order that was obtained under 42 C.F.R. Part 2, Subpart E, we are compelled by federal law not to release any information.

This decision was reached after a thorough review of the federal laws and regulations governing the confidentiality of alcohol and drug abuse patient records, and is not intended in any way to impede justice.

Sincerely,

_____

Program Director

Filing Complaints of Discrimination with Michigan Department of Civil Rights

If you believe someone has discriminated against you in any of the areas protected by law, you or your representative may contact our nearest office for assistance. Contact may be made by telephone, in person, by US mail or by email. If you contact us by US mail or email, please include your name, address, and a telephone number where you can be reached during the day. A civil rights representative will answer your questions and advise you regarding the filing of a complaint or offer you other alternatives, as appropriate, to address your concern.

To File A Complaint

If you seek to file a complaint, a rights specialist will conduct a detailed interview to decide whether your situation meets the jurisdictional requirements defined by law. You will be asked many questions, and your ability to provide the answers will make the process much easier. Please have the following information available:

- Name and address of the employer, school, agency or public place or service about which you want to complain. Information about the total number of employees the employer has and the type of work done.
- Dates of any incidents you want to complain about that occurred within the past 180 days.
- Names of any persons who discriminated against you, if you know their names. Describe them if you do not know their names.
- Names, addresses and telephone numbers of any witnesses to incidents you want to complain about. If you do not know the names or contact information of witnesses, provide the best information you have about how they might be located.
- Copies of any work policies which you feel were unequally applied.
- Copies of any memos or disciplines you want to complain about.
- Information about any other actions you have taken regarding the cited incidents.
- Names of people, if you know of any, who did the same thing you did and were not treated the way you were. Be prepared to describe their circumstances including approximate dates, persons who treated these people differently from you, and names of persons who could verify the circumstances.
- Name and contact information for your union representative, if applicable. Name and address of union local, if applicable.
- The status of a grievance, if you have filed one.

If it is determined that your situation falls within the jurisdiction of the Michigan Department of Civil Rights, the rights specialist will, with your assistance, draft a complaint. You will be asked to sign the complaint, and swear or affirm before a Notary Public that the statement in the complaint is true to the best of your knowledge or belief. You will be given a copy of the complaint and a letter explaining what will happen next, and advising you of your rights under the Elliott-Larsen and/or Persons With Disabilities Civil Rights Act, and your responsibility to keep the Michigan Department of Civil Rights informed of your whereabouts and current on matters relating to your complaint.

A Complaint Is Not A Lawsuit

The Michigan Department of Civil Rights is an administrative agency representing the interest of the state. During the investigation of a complaint, the Department represents neither the claimant nor the responding party -- it represents the best interest of the people of Michigan. Therefore, neither is a complaint a lawsuit for the claimant, nor are lawyers provided during the filing or investigative process.

If You Have Questions

If you have questions regarding the information presented above, you may contact the Service Center for clarification by telephone, fax or email:

Phone: (313) 456-3700
Fax: (313) 456-3701
WATS: (800) 482-3604
TTY: (877) 878-8464
Email: MDCRServiceCenter@michigan.gov

Office for Civil Rights

Federal civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, together protect your fundamental rights of nondiscrimination and health information privacy. Civil Rights help to protect you from unfair treatment or discrimination, because of your race, color, national origin, disability, age, sex (gender), or religion. The Privacy Rule protects the privacy of your health information; it says who can look at and receive your health information, and also gives you specific rights over that information. In addition, the Patient Safety Act and Rule establish a voluntary reporting system to enhance the data available to assess and resolve patient safety and health care quality issues and provides confidentiality protections for patient safety concerns.

How to File a Complaint with CIVIL RIGHTS

If you feel a health care provider, or state or local government agency, has discriminated against you (or someone else) based on race, national origin, disability, or age, you may file a civil rights complaint. OCR can investigate disability-based discrimination complaints against programs operated by HHS. Under certain statutes and regulations, OCR also has limited authority to investigate complaints of discrimination based on sex and religion.

For more information about the Civil Rights Laws and Regulations we enforce, please review our Understanding Civil Rights section or look at our Frequently Asked Question (FAQs).

The Case Resolution Manual for Civil Rights Investigations (CRM) provides OCR staff and managers with the procedures and strategies designed to promptly and effectively evaluate, investigate, and resolve complaints and compliance reviews, and to enforce violation findings where warranted.

COMPLAINT REQUIREMENTS - Your complaint must:

1. Be filed in writing, either on paper or electronically, by mail, fax, or e-mail;
2. Name the healthcare or social service provider involved, and describe the acts or omissions, you believed violated the civil rights laws or regulations; and

3. Be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause."

ANYONE CAN FILE! - Anyone can file written complaints with OCR. We recommend that you use the Civil Rights Discrimination Complaint Form Package. You can also request a copy of this form from an OCR regional office. If you need help filing a complaint or have a question about the complaint or consent forms, please email OCR at OCRMail@hhs.gov.

THE CIVIL RIGHTS NONDISCRIMINATION LAWS AND REGULATIONS PROHIBIT RETALIATION - Under Civil Rights Laws an entity cannot retaliate against you for filing a complaint. You should notify OCR immediately in the event of any retaliatory action.

HOW TO SUBMIT YOUR COMPLAINT TO OCR - *To submit a complaint to OCR, please use one of the following methods.*

If you mail or fax the complaint, be sure to send it to the appropriate OCR regional office based on where the alleged violation took place. OCR has ten regional offices, and each regional office covers specific states. Send your complaint to the attention of the OCR Regional Manager. *You do not need to sign the complaint and consent forms when you submit them by email because submission by email represents your signature.*

File A Complaint Using Our Civil Rights Discrimination Complaint Form Package

File A Complaint Without Using Our Civil Rights Discrimination Complaint Package

- If you choose not to use the OCR Civil Rights Discrimination Complaint Form Package, please provide the information specified below by either:
    1.
        1. mail or fax to the appropriate OCR regional office; or
        2. email to OCRComplaint@hhs.gov.

    If you prefer, you may submit a ***written*** complaint in your own format. Be sure to include the following information:

    2. Your name
    3. Full address
    4. Telephone numbers (include area code)
    5. E-mail address (if available)
    6. Name, full address and telephone number of the person, agency or organization you believe discriminated against you.
    7. Brief description of what happened. How, why, and when you believe your (or someone else's) civil rights were violated.
    8. Any other relevant information
    9. Your signature and date of complaint

    If you are filing a complaint on someone's behalf, also provide the name of the person on whose behalf you are filing.

The following information is ***optional***:

10.
    1. Do you need special accommodations for us to communicate with you about this complaint?
    2. If we cannot reach you directly, is there someone else we can contact to help us reach you?
    3. Have you filed your complaint somewhere else? If so, where?

Region V - Chicago (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)
Valerie Morgan-Alston, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Voice Phone (312)886-2359
FAX (312)886-1807
TDD (312)353-5693

Resources Necessary for an Effective Rights Office

http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_4901---,00.html

- ✓ Mental Health Code, as amended (ORR web)
- ✓ Administrative Rules (ORR web)
- ✓ Rights Booklet www.MACMHB.org
- ✓ Incident Report Forms (DCH office services)
- ✓ Rights Complaint Form (DCH 2550) (DCH office services) (ORR web)
- ✓ Listing of Rights Categories
- ✓ Notification Posters
- ✓ Abuse-Neglect Reporting Posters (large - DCH office services) (small – ORR web)
- ✓ Copy of DCH-CMHSP Master Contract (CMH's – PHP & Master Fund)
- ✓ Copy of CMHSP-LPH/U Contract
- ✓ Union Contracts
- ✓ Access to or Copies of Relevant Laws (# 3)
  - HIPAA http://www.hipaa.org
  - Civil Rights, Privacy Rights, http://www.hhs.gov/ocr
  - Substance Abuse confidentiality 42CFR.part 2 http://www.treatment.org
  - SA technical assistance CSAT TIA http://www.treatment.org
  - Childrens' Protective Services Act (PA 238 of 1975, as amended)
  - Adult Protective Serivces Act (PA 519 of 1982, as amended)
  - Americans with Disabilities Act (ADA)
  - Michigan Persons with Disabilities Civil Rights Act (PA 220 of 1976, as amended)
  - Section 504 of the Federal Rehabilitation Act of 1973
  - Bullard-Plawecki Employee Right to Know Act (#14)
  - Information on Michigan Protection and Advocacy Services and other advocacy groups (#23) http://www.mpas.org/HomePage.asp http://namimi.org
  - EPIC (# 22) http://law.justia.com/michigan/codes/mcl-chap700/mcl-act-386-of-1998.html
- ✓ Attorney Grievance Forms http://www.agcmi.com/pages/RiRequestform.htm
- ✓ Professional Staff – Complaint form and Citizen's guide for filing a health care facility complaint http://www.michigan.gov/mdch/0,1607,7-132-27417_27647---,00.html
- ✓ Reference Books
  - Physicians Desk Reference http://www.gettingwell.com/
  - Merck Manual http://www.merck.com/pubs/mmanual/
  - Law Dictionary http://www.duhaime.org/dictionary/diction.htm
  - or http://dictionary.law.com/
  - Medical Dictionary http://cancerweb.ncl.ac.uk/omd/
  - DSM (Diagnostic and Statistical Manual) IV (not to be used by ORR for diagnosis)
  - http://www.behavenet.com/capsules/disorders/dsm4classification.htm
  - http://www.behavenet.com/capsules/disorders/dsm4tr.htm
  - http://www.bridges4kids.org/Rules.html http://www.bridges4kids.org/f2f/

www.michiganlegislature.org

www.michigan.gov/mdch

Case File Sheet

Rights Complaint #:_____ Log as: _____

Date received _____ Date of incident _____

Complainant _____ Name of recipient _____

Name of accused _____ MHC§: _____

Rights Advisor assigned: _____

Date Opened:_____

Case Resolved by: ☐ Intervention ⟶ ☐ Substantiated ☐ Not substantiated
☐ Investigation ⟶ ☐ Substantiated ☐ Not substantiated

Notification: ☐ APS ☐ CPS ☐ CIS ☐ Law Enforcement ☐ Other _____

The following documents are contained in the Individual Case File

☐ Recipient Rights Complaint
☐ Incident Report, if applicable
☐ Acknowledgement Letter (within 5 Days)
☐ Status Report, if applicable Date sent: (30) _____ (60) _____
☐ Report of Investigative Findings – Date sent to Director _____
☐ Intervention – Date completed _____
☐ Documentation of Remedial/Corrective Action – Date received _____
☐ Summary Report – Date received from Director/mailed _____
  ☐ Summary Report – Appeal notice included
☐ Summary Notification (completion of plan <u>without</u> changes) – Date sent _____
☐ Summary Notification (completion of plan <u>with</u> changes) – Date sent _____
  ☐ Summary Notification/Appeal notice (action) included

DOCUMENTS EXAMINED:

	Name	Date Examined	Copy in File Yes	Copy in File No
1.				
2.				
3.				
4.				
5.				
6.				
7.				

WRITTEN STATEMENTS:

	Name	Date Examined	Copy in File Yes	Copy in File No
1.				
2.				
3.				
4.				
5.				

Case File Sheet

PERSONS INTERVIEWED:

	Name	Date Interviewed	Notes in File Yes	No
1.	_____	_____		
2.	_____	_____		
3.	_____	_____		
4.	_____	_____		
5.	_____	_____		
6.	_____	_____		
7.	_____	_____		

Other: