COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
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)
   a. ____________________________________________
   b. ____________________________________________
   c. ____________________________________________

3. NAME(S) OF PERSON(S) COMPLAINED OF
   (if any and if known)
   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):

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[ ] 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