ANNE ARUNDEL COUNTY MENTAL HEALTH AGENCY

P.O. Box 6675, MS-3230, 1 Truman Parkway, Suite 101, Annapolis, MD 21401
Telephone 410-222-7858

CONCERNS/COMPLAINT REPORT

WRITER OF COMPLAINT (if other than consumer**) _____**
RELATIONSHIP _____

MAILING ADDRESS_____
_____

TELEPHONE (Home) _____ (Work) _____

CONCERNS/COMPLAINT AGAINST_____

If your complaint is against one of your service providers, have you made a Complaint through their complaint program? YES___ NO___. If the answer is YES, please fill in the remainder of the form and send it to the above address. If the answer is NO, you may wish to consider contacting your provider first. If that contact is not satisfactory, then we are available as the next level of recourse for you. However, you may still contact us first, if you wish.

SUMMARY OF COMPLAINT/CONCERN

Name **Date:**

(Please attach additional pages, if necessary)

What do you want to see happen to fix this problem?

Signature **Date**

In order to pursue the complaint in your name, we need you to sign the following release statement. If you wish to remain anonymous, do not sign the following release statement. However, with no signature we will only be able to discuss this with the provider in general terms and will not be able to get a specific response related to your circumstances.

I (name) _____, hereby give permission to the Anne Arundel County Mental Health Agency to release a copy of the above Concerns/complaints to_____ (provider agency name) for the purpose of investigation and problem resolution.

_____
Signature

Please send to: Anne Arundel County Mental Health Agency
PO Box 6675, MS-3230
1 Truman Parkway, Suite 101
Annapolis, MD 21401
OR FAX: 410-222-7881