

Bureau of Licensure and Certification

Complaint Form

This complaint may be subject to a public records request. You may file this complaint **ANONYMOUSLY**, only by **NOT** providing your information. If you remain anonymous, OMHAS will not be able to contact you to obtain additional information or notify you of the results of the complaint investigation.

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- | | | |
|--|---|--|
| <input type="checkbox"/> Community Behavioral Health Agency | <input type="checkbox"/> Halfway House | <input type="checkbox"/> Uncertain of Type |
| <input type="checkbox"/> Residential Facility (Non Substance Use Disorder) | <input type="checkbox"/> Driver Intervention Program | <input type="checkbox"/> Unlicensed Facility |
| <input type="checkbox"/> Residential / Halfway House (Substance Use Disorder) | <input type="checkbox"/> Private Psychiatric Hospital | |
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Skip to Section II if you wish to remain anonymous.

Section I Complainant Information - Complete only if you wish to receive our acknowledgement and notification letters with the result of the complaint investigation:

Complainant Name:

Street Address:

City: State: Zip Code:

Phone Number: E-mail:

Section II Facility Information: This information can also be obtained from the posted license/certificate

Facility Name:

Street Address:

City: **Ohio** Zip Code:

Phone Number: County:

Section III Resident / Consumer Information:

Resident/Consumer Name (A):

Is the Resident/Consumer still in the facility? Yes No

Date of Birth: Relationship to Res/Consumer:

Resident/Consumer Name (B)

Is the Resident/Consumer still in the facility? Yes No

Date of Birth: Relationship to Res/Consumer:

Facility Name: _____

Section IV Alleged Wrongdoer(s) Information - If applicable or known

Name (A):	<input type="text"/>	Title	<input type="text"/>
Name (B):	<input type="text"/>	Title	<input type="text"/>
Name (C):	<input type="text"/>	Title	<input type="text"/>

Section V Current Status - Please list other applicable agencies or authorities that have been notified:

Name of Agency (A)	<input type="text"/>		
Contact Name (A):	<input type="text"/>	Title	<input type="text"/>
Phone Number:	<input type="text"/>	E-mail:	<input type="text"/>
Name of Agency (B)	<input type="text"/>		
Contact Name (B):	<input type="text"/>	Title	<input type="text"/>
Phone Number:	<input type="text"/>	E-mail:	<input type="text"/>

Section VI Complaint Description - What describe(s) the resident/consumer complaint:

<input type="checkbox"/> Neglect	<input type="checkbox"/> Physical Harm	<input type="checkbox"/> Defraud	<input type="checkbox"/> Potential Harm	<input type="checkbox"/> Use of Force
<input type="checkbox"/> Restraint	<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Use of Force	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Psychological Harm
<input type="checkbox"/> Medication Error	Other <input type="text"/>	Other <input type="text"/>		

Section VII Narrative When did this incident take place: Date: Time:

Witness (A):	<input type="text"/>	Phone Number	<input type="text"/>
Witness (B):	<input type="text"/>	Phone Number	<input type="text"/>

Provide a narrative description of your complaint (please attach additional information if needed):

Please submit this form via mail, e-mail, or fax (**chose one method only**) to:
OhioMHAS - Attention Licensure and Certification

30 E Broad Street, Suite 742
Columbus, Ohio 43215-3430

LicCert@mha.ohio.gov

Fax (614) 485-9739