

RECIPIENT RIGHTS STATE LEVEL
INVESTIGATION REPORT

TO BE COMPLETED BY STATE COORDINATOR

To Recipient/Client: Please Read
Instructions on Page 2

Program Name: _____

License No.: _____

Complaint No.: _____

Date Appeal Filed: _____

FINDINGS: THE ALLEGATIONS IN THIS APPEAL HAVE BEEN INVESTIGATED. THE FINDINGS AND REMEDIAL ACTION PLAN:

- Support the recipient rights coordinating agency investigation report dated _____
- Support, in part, the recipient rights coordinating agency investigation report dated _____
- Do not support the recipient rights coordinating agency investigation report dated _____
- Are inconclusive

1A. Preliminary Report: The investigation has not been completed for the following reason(s):

The report will be completed on the following date: _____

NARRATIVE SUMMARY OF INVESTIGATION AND FINDINGS:

1. REMEDIAL ACTION: Remedial Action not required Remedial action required as follows

1. SUBMITTED BY: _____ State Rights Coordinator's Signature _____ Date

Printed Name

1. RECIPIENT CERTIFICATION: I certify that I have received a copy of this report and have been informed of my right to appeal within 15 working days. (If mailed, indicate date)

Recipient's Signature

Date (signed or mailed)

Printed Name

COPIES TO: DCH/BHS/L&C/SALS
PROGRAM
COORDINATING AGENCY

AN APPEAL MUST BE RECEIVED BY: _____
Date

INSTRUCTIONS FOR THE RECIPIENT/CLIENT

THIS FORM CONTAINS THE OFFICIAL STATE LEVEL RESPONSE TO YOUR RECIPIENT RIGHTS APPEAL.

YOU SHOULD RECEIVE THIS REPORT NO LATER THAN 30 WORKING DAYS AFTER THE STATE RIGHTS COORDINATOR RECEIVED YOUR APPEAL.

IF THERE IS SOME REASON FOR TAKING MORE THAN 30 WORKING DAYS TO RESPOND TO YOUR APPEAL, YOU WILL RECEIVE A PRELIMINARY REPORT WITHIN 30 WORKING DAYS WITH AN EXPLANATION OF WHY IT IS TAKING LONGER, AND THE DATE THE REPORT WILL BE COMPLETED.

WHEN YOU RECEIVE THIS REPORT, YOU HAVE 15 WORKING DAYS TO DECIDE TO ACCEPT THE FINDINGS AND/OR ACTION PLAN OR TO FILE AN APPEAL. THE LAST DATE UPON WHICH YOU MAY FILE AN APPEAL IS NOTED IN THE LOWER RIGHT-HAND CORNER OF THE FORM.

NO ACTION ON YOUR PART BY THE INDICATED DATE MEANS YOU HAVE ACCEPTED THE FINDINGS AND ACTION PLAN AS A SOLUTION TO YOUR COMPLAINT.

IF YOU WANT TO FILE ANOTHER APPEAL, YOU MAY WRITE TO THE ADDRESS BELOW TO REQUEST A HEARING ACCORDING TO THE ADMINISTRATIVE PROCEDURES ACT. YOUR LETTER SHOULD IDENTIFY THE PROGRAM NAME, LICENSE NUMBER AND COMPLAINT NUMBER AS SHOWN IN THE BOX IN THE UPPER RIGHT CORNER ON THE FRONT OF THIS FORM. YOUR LETTER SHOULD ALSO DESCRIBE THE REASON YOU ARE FILING AN APPEAL AND WHAT ACTION YOU WANT TAKEN. YOU WILL THEN BE NOTIFIED OF THE DATE, TIME AND PLACE WHERE YOUR HEARING WILL BE HELD.

MAIL THE LETTER TO: MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS
DIVISION OF LICENSING & CERTIFICATION
SUBSTANCE ABUSE LICENSING SECTION
P.O. BOX 30664
LANSING, MICHIGAN 48909

NEW COMPLAINTS

IF YOU ACCEPT THE REMEDIAL ACTION PLAN IN THIS REPORT BUT LATER DECIDE IT ISN'T BEING PUT INTO PLACE AS DESCRIBED IN THIS REPORT, YOU MAY FILE A NEW RECIPIENT RIGHTS COMPLAINT.

BHS-LC-906 (Revised 04/04)
By Authority: PA 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, political beliefs or disability. If you need help with reading, writing, hearing, etc. under the Americans with Disabilities Act, you may make your needs known to this Agency.