PHILADELPHIA COMMUNITY MENTAL HEALTH SYSTEM
COMPLAINT FORM

Section 1

TO BE COMPLETED BY INDIVIDUAL WITH COMPLAINT

Print Name: _____ Date of Complaint: _____
Name of Agency/Program: _____
Address Where Complaint Originated:
_____
_____
Complaint: _____
_____
_____
_____
_____
_____
_____
Your Signature: _____ Date: _____
_____

TO BE COMPLETED BY SUPERVISOR (within 7 days)

Response: _____
_____
_____
_____
_____
Signature/Title: _____ Date: _____

Section 2

TO BE COMPLETED BY INDIVIDUAL WITH COMPLAINT

Are you satisfied with the response given above? Yes _____ No _____
Comments: _____
_____
_____
Your Signature: _____ Date: _____
_____

TO BE COMPLETED BY MENTAL HEALTH OR EXECUTIVE DIRECTOR (within 7 days)

Response: _____
_____
_____
_____
_____
Director's Signature: _____ Date: _____

PHILADELPHIA COMMUNITY MENTAL HEALTH SYSTEM
COMPLAINT FORM

Section 3

TO BE COMPLETED BY INDIVIDUAL WITH COMPLAINT

Are you satisfied with the response from the Director? Yes _____ No _____
Comments: _____
_____
_____
Your Signature: _____ Date: _____
_____

TO BE COMPLETED BY MH ADMINISTRATOR AT OMH/MR (within 7 days)

Response: _____
_____
_____
_____
_____
MH Administrator's Signature: _____ Date: _____

Section 4

TO BE COMPLETED BY INDIVIDUAL WITH COMPLAINT

Are you satisfied with the response from the MH Administrator? Yes __ No __
Comments: _____
_____
_____
Your Signature: _____ Date: _____
Do you wish to appeal to the Human Rights Committee? Yes _____ No _____
_____

TO BE COMPLETED BY HUMAN RIGHTS COMMITTEE CHAIRPERSON

Date received _____
Date of Human Rights Committee hearing (within 30 days)
_____
Date recommendations sent to Deputy Health Commissioner: _____
Action taken by Deputy Health Commissioner: _____
_____
_____
_____
_____
_____
_____
_____
_____
Signature of HRC Chairperson: _____ Date: _____