



Polk County Behavioral Health Client Complaint Form

Please complete all of this form, sign and date it. Use the back of this page if you need to. You will receive a response within 5 business days from the date we receive this form. If you do not agree with the response, you have the right to file an appeal.

Date: _____

Your Name: _____ ☐ I am the legal guardian of the Client

Client's Name (if you are not the client): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Client's Date of Birth: _____

Please tell us what happened (When did it happen? Who was involved?) *If necessary, please use additional space on the back side of this form ➔*

How can we help make it right?

EXPEDITED REVIEW: *You have the right to ask for a faster complaint process if you feel that your life or health is in immediate and serious danger because of this matter.*

Are you requesting an Expedited Review? YES ☐ NO ☐

You may hand in this form or mail it to:

Polk County Behavioral Health
Attn: Complaints Representative
182 SW Academy Street Dallas, OR 97338

This image shows a full page of blank white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page, providing a template for writing or drawing. There are no margins, text, or other markings present.