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* ➔

_____

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How can we help make it right?

_____

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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