**7810**

**410-637-1900**

**Phone number to report: Phone: Ext:**

**Initial contact to BHSB: Date:** **Time:**

**BHSB staff receiving initial call: Name:**

**Date: Time:**

**Anonymous Reporter:**

**Complainant/Incident Reporter’s Contact Information:**

**Name:**

**Address: City: State: Zip:**

**Email Address:**

**Phone: Fax:**

**Client’s Name & Contact Information (if different than complainant):**

**Name:**

**Address: City: State: Zip:**

**Email Address:**

**Phone: Fax:**

**Client**  **Provider: BHSB Funded Yes No**

 **Family Other (Please list):**

**Provider’s Contact Information**

**Name:**

**Address: City: State: Zip:**

**Email Address:**

**Phone: Fax:**

**Has the person filing the complaint utilized the agency grievance procedure or contacted the program? Yes No**

**I. Description of complaint/incident (including dates, times, and all persons involved) Date:**

**Staff responsible for follow-up:**

**II. Action taken by BHSB (including dates, times all persons involved, and outcomes) Date:**

**III. Provider Response Date:**

**IV. Complaint/incident resolution follow-up (if applicable) Date:**

**V. Action required (i.e. Correction Action Plan, Policy Revision, etc.) Date due:**

 **Quality Coordinator** **Date:**

 **Program Lead Date:**

 **Supervisor Date:**

 **Director Date:**

 **Vice President Date:**

 **Recorded on Complaint Log Date:**