**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: Yes** [ ]  **No** [ ]

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

**Name:**

**Phone#: Email:**

**Address:**

**City: State: Zip:**

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

[ ]  **Family** [ ]  **Other (Please list):**

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

**Name:**

**Phone#: Email:**

**Address:**

**City: Fax: State: Zip:**

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

**Provider’s Contact Information**

**Name:**

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

**Email Address:**

**Phone: Fax:**

**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:**

[ ]  **Vice President Date:**

[ ]  **Recorded on Complaint Log Date:**