

**RICHLAND COUNTY HEALTH AND HUMAN SERVICES
COMPLAINT FORM**

Please complete this form within 45 calendar days of the alleged incident and return to:

Richland County Health and Human Services
221 West Seminary Street
Richland Center, WI 53581

Name of Person Filing Complaint: _____

Address: _____

Telephone Number: _____

Name of Consumer
(If Not Person Filing Complaint): _____

Address: _____

Telephone Number: _____

Complaint Made:

Complaint Against:

(Check all that apply.)

- | | | | | |
|-----------------------------------|-------------------------------------|---|--|---|
| <input type="checkbox"/> Verbally | <input type="checkbox"/> In Writing | <input type="checkbox"/> Administration | <input type="checkbox"/> ADRC | <input type="checkbox"/> Child & Youth Services |
| | | <input type="checkbox"/> Economic Support | <input type="checkbox"/> Public Health | <input type="checkbox"/> Behavioral Health Services |
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Describe your complaint. State all facts, including date, time, place of incident, names of others involved, witnesses (if any), etc. Attach other sheets if necessary.

Proposed Remedy:

Signature: _____ Date Submitted: _____

Date Received: _____