SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Office of Recipient Rights Action Verification Form

Recipient Rights
Complaints
Appeals

Recipient(s) (If you type recipient name on this form, please do not send by regular e-mail)

Provider Agency (Agencies)	Provider/Respondent	Report #

Instructions: Please review the attached Office of Recipient Rights Intervention/Investigation Report. Document below the steps that have been taken or will be taken to comply with the recommendations in the report (include what action was/will be taken, when it was/will be taken and by whom). Attach additional pages if necessary. Sign and date your response and send the completed form to:

Fax: (989) 797-3595

Please note: If disciplinary action has been recommended, please indicate which of the following actions was/will be taken with staff: written reprimand, suspension, demotion, staff transfer or employment termination.

This completed form is due back to the Office of Recipient Rights on or before: _____

Action Taken:
PLEASE PROVIDE COPIES OF ANY ACTION TAKEN

Signature and Title: _____ **Date:** _____