

**RECIPIENT RIGHTS STATE LEVEL  
INVESTIGATION REPORT**

**TO BE COMPLETED BY STATE COORDINATOR**

**To Recipient/Client: Please Read  
Instructions on Page 2**

**Program Name:** \_\_\_\_\_

**License No.:** \_\_\_\_\_

**Complaint No.:** \_\_\_\_\_

**Date Appeal Filed:** \_\_\_\_\_

1. **FINDINGS:** THE ALLEGATIONS IN THIS APPEAL HAVE BEEN INVESTIGATED. THE FINDINGS AND REMEDIAL ACTION PLAN:

- Support the recipient rights coordinating agency investigation report dated \_\_\_\_\_
- Support, in part, the recipient rights coordinating agency investigation report dated \_\_\_\_\_
- Do not support the recipient rights coordinating agency investigation report dated \_\_\_\_\_
- Are inconclusive

1A. **Preliminary Report:**  The investigation has not been completed for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_

The report will be completed on the following date: \_\_\_\_\_

2. **NARRATIVE SUMMARY OF INVESTIGATION AND FINDINGS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. **REMEDIAL ACTION:**  Remedial Action not required  Remedial action required as follows

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. **SUBMITTED BY:** \_\_\_\_\_

**State Rights Coordinator's Signature**

**Date**

\_\_\_\_\_  
**Printed Name**

5. **RECIPIENT CERTIFICATION:** I certify that I have received a copy of this report and have been informed of my right to appeal within 15 working days. (If mailed, indicate date)

\_\_\_\_\_  
**Recipient's Signature**

\_\_\_\_\_  
**Date (signed or mailed)**

\_\_\_\_\_  
**Printed Name**

**COPIES TO: DCH/BHS/L&C/SALS  
PROGRAM  
COORDINATING AGENCY**

**AN APPEAL MUST BE RECEIVED BY:** \_\_\_\_\_  
**Date**

**INSTRUCTIONS FOR THE RECIPIENT/CLIENT**

THIS FORM CONTAINS THE OFFICIAL STATE LEVEL RESPONSE TO YOUR RECIPIENT RIGHTS APPEAL.

YOU SHOULD RECEIVE THIS REPORT NO LATER THAN 30 WORKING DAYS AFTER THE STATE RIGHTS COORDINATOR RECEIVED YOUR APPEAL.

IF THERE IS SOME REASON FOR TAKING MORE THAN 30 WORKING DAYS TO RESPOND TO YOUR APPEAL, YOU WILL RECEIVE A PRELIMINARY REPORT WITHIN 30 WORKING DAYS WITH AN EXPLANATION OF WHY IT IS TAKING LONGER, AND THE DATE THE REPORT WILL BE COMPLETED.

**WHEN YOU RECEIVE THIS REPORT, YOU HAVE 15 WORKING DAYS TO DECIDE TO ACCEPT THE FINDINGS AND/OR ACTION PLAN OR TO FILE AN APPEAL. THE LAST DATE UPON WHICH YOU MAY FILE AN APPEAL IS NOTED IN THE LOWER RIGHT-HAND CORNER OF THE FORM.**

**NO ACTION ON YOUR PART BY THE INDICATED DATE MEANS YOU HAVE ACCEPTED THE FINDINGS AND ACTION PLAN AS A SOLUTION TO YOUR COMPLAINT.**

IF YOU WANT TO FILE ANOTHER APPEAL, YOU MAY WRITE TO THE ADDRESS BELOW TO REQUEST A HEARING ACCORDING TO THE ADMINISTRATIVE PROCEDURES ACT. YOUR LETTER SHOULD IDENTIFY THE PROGRAM NAME, LICENSE NUMBER AND COMPLAINT NUMBER AS SHOWN IN THE BOX IN THE UPPER RIGHT CORNER ON THE FRONT OF THIS FORM. YOUR LETTER SHOULD ALSO DESCRIBE THE REASON YOU ARE FILING AN APPEAL AND WHAT ACTION YOU WANT TAKEN. YOU WILL THEN BE NOTIFIED OF THE DATE, TIME AND PLACE WHERE YOUR HEARING WILL BE HELD.

MAIL THE LETTER TO: MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
BUREAU OF HEALTH SYSTEMS  
DIVISION OF LICENSING & CERTIFICATION  
SUBSTANCE ABUSE LICENSING SECTION  
P.O. BOX 30664  
LANSING, MICHIGAN 48909

**NEW COMPLAINTS**

IF YOU ACCEPT THE REMEDIAL ACTION PLAN IN THIS REPORT BUT LATER DECIDE IT ISN'T BEING PUT INTO PLACE AS DESCRIBED IN THIS REPORT, YOU MAY FILE A NEW RECIPIENT RIGHTS COMPLAINT.