Bureau of Licensure and Certification
Complaint Form

This complaint may be subject to a public records request. You may file this complaint **ANONYMOUSLY**, only by **NOT** providing your information. If you remain anonymous, OMHAS will not be able to contact you to obtain additional information or notify you of the results of the complaint investigation.

- ☐ Community Behavioral Health Agency
- ☐ Halfway House
- ☐ Uncertain of Type
- ☐ Residential Facility **(Non** Substance Use Disorder)
- ☐ Driver Intervention Program
- ☐ Unlicensed Facility
- ☐ Residential / Halfway House (Substance Use Disorder)
- ☐ Private Psychiatric Hospital

Skip to Section II if you wish to remain anonymous.

Section I Complainant Information - Complete only if you wish to receive our acknowledgement and notification letters with the result of the complaint investigation:

Complainant Name:

Street Address:

City: State: Zip Code:

Phone Number: E-mail:

Section II Facility Information: This information can also be obtained from the posted license/certificate

Facility Name:

Street Address:

City: **Ohio** Zip Code:

Phone Number: County:

Section III Resident / Consumer Information:

Resident/Consumer Name (A):

Is the Resident/Consumer still in the facility? ☐ Yes ☐ No

Date of Birth: Relationship to Res/Consumer:

Resident/Consumer Name (B)

Is the Resident/Consumer still in the facility? ☐ Yes ☐ No

Date of Birth: Relationship to Res/Consumer:

Facility Name: ______________________________

Section IV Alleged Wrongdoer(s) Information - If applicable or known

Name (A): ______________________________ Title ______________

Name (B): ______________________________ Title ______________

Name (C): ______________________________ Title ______________

Section V Current Status - Please list other applicable agencies or authorities that have been notified:

Name of Agency (A) ______________________________

Contact Name (A): ______________________________ Title ______________

Phone Number: ______________ E-mail: ______________________________

Name of Agency (B) ______________________________

Contact Name (B): ______________________________ Title ______________

Phone Number: ______________ E-mail: ______________________________

Section VI Complaint Description - What describe(s) the resident/consumer complaint:

☐ Neglect	☐ Physical Harm	☐ Defraud	☐ Potential Harm	☐ Use of Force
☐ Restraint	☐ Sexual Assault	☐ Use of Force	☐ Verbal Abuse	☐ Psychological Harm
☐ Medication Error	Other ______________		Other ______________	

Section VII Narrative

When did this incident take place: Date: ______________ Time ______________

Witness (A): ______________________________ Phone Number ______________

Witness (B): ______________________________ Phone Number ______________

Provide a narrative description of your complaint (please attach additional information if needed):

Please submit this form via mail, e-mail, or fax (chose **one** method only) to:

OhioMHAS - Attention Licensure and Certification

☐ 30 E Broad Street, Suite 742
Columbus, Ohio 43215-3430

☐ IncidentReport@mha.ohio.gov

☐ Fax (614) 485-9739