STATE OF IOWA DEPARTMENT OF Health and Human

SERVICES

Complaint Form/Licensed Substance Use Disorder and/or Problem Gambling Treatment Program

Please Print or Type	PERSON REGISTERING COMPLAINT	Provide all information
Name:		Home Phone:
Address:		City/State/Zip

Email:

COMPLAINT REGISTERED AGAINST (Licensed Programs)

Agency Name:

Staff Name (if applicable):

Agency Address/City/Location Name (if applicable):

	DETAILS OF COMPLAINT
1.	Have you complained directly to the licensed program? Yes No When: How: Telephone Letter Other (please specify):
2.	Did the Licensed program respond? Yes No Action taken:
3.	Provide a detailed description of the complaint below:
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Would you be willing to testify in an administrative l	hearing regarding the matter: Yes 🗌 No 🗌			
Do you wish to remain anonymous: Yes 🗌 No 🗌				
I certify that all information which I have given here	in to be true, correct, and complete to the best of my knowledge.			
Signature	Date			
Please mail to:	Complaint # BH			
Iowa Department of Public Health	(for office use only)			
Division of Behavioral Health				
Lucas State Office Building				
Attn.: Health Facilities Officer				
Des Moines, Iowa 50319-0075				

PLEASE ATTACH COPIES OF RELATED DOCUMENTS. DO NOT SEND ORIGINALS