Licensed Substance Use Disorder and/or Problem Gambling Treatment Program

Complaint Form

PERSON REGISTERING COMPLAINT	
Name:	
Address:	Phone Number:
City, State Zip Code:	Email:

COMPLAINT REGISTERED AGAINST (Licensed Programs)
Agency Name:
Staff Name (if applicable):
Location Name (if applicable), Agency Address, City:

DETAILS OF COMPLAINT

1. Have you complained directly to the licensed program? ☐ Yes ☐ No
   When:

   How: ☐ Phone ☐ Letter ☐ Other (please specify):

2. Did the licensed program respond? ☐ Yes ☐ No

   Action taken:

3. Provide a detailed description of the complaint below:

Would you be willing to testify in an administrative hearing regarding the matter:

☐ Yes ☐ No

Do you wish to remain anonymous: ☐ Yes ☐ No

I certify that all information which I have given herein to be true, correct, and complete to the best of my knowledge.

Signature: Date:

Please mail to:

Iowa Department of Heath an Human Services
Division of Behavioral Health
321 E 12th St Floor 2
Des Moines, IA 50319

Email to: sud.pg.license@hhs.iowa.gov

PLEASE ATTACH COPIES OF RELATED DOCUMENTS. **DO NOT SEND ORIGINALS**