GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

INTERNAL RESOLUTION COMPLAINT FORM

An individual, or any representative, acting on behalf of any individual, may file a complaint against another individual, or any DDS provider. This form may be completed in writing, or may be verbally requested to be completed by this office.

Name of Individual

Name of Person Filing Complaint Relationship (if other than individual)

Address (Mailing Address) (City) (State) (Zip)

Telephone Number Email (if available)

Provider Name

The following complaint concerns the possible violation of the following right(s): {check all that apply}

- ☐ Excessive or Unnecessary Medication
- ☐ Freedom from Restraint & Harm
- ☐ Religious Freedom
- ☐ Physical Exercise & Healthy Diet
- ☐ Community Activities
- ☐ Privacy (including restrictions on sexual activity)
- ☐ Other: _____
- ☐ Visitation Rights
- ☐ Telephone Usage
- ☐ Writing Materials
- ☐ Personal Property
- ☐ Finance Control

Please describe your complaint including the following as applicable: (a written statement may be attached or used instead of the form)

- A statement of facts upon which the complaint is based
- The party that the complaint is being made against
- A proposed solution to the problem

Description of Complaint:

Submit your complaint to the DDA Rights and Advocacy Specialist.

_____

Signature Date

For internal use only: Method of Complaint: Phone ☐ In-Person ☐ Mail ☐
Other: _____

_____ - _____

Received by: Date Tracking Number
(E.g. 07.29.10-001)