

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.

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Name of Individual

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Name of Person Filing Complaint

Relationship (if other than individual)

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Address (Mailing Address)

(City)

(State)

(Zip)

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Telephone Number

Email (if available)

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Provider Name

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

Excessive or Unnecessary Medication

Visitation Rights

Freedom from Restraint & Harm

Telephone Usage

Religious Freedom

Writing Materials

Physical Exercise & Healthy Diet

Personal Property

Community Activities

Finance Control

Privacy (including restrictions on sexual activity)

Other:

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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

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Description of Complaint:

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Submit your complaint to the DDA Rights and Advocacy Specialist.

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Signature

Date

For internal use only: Method of Complaint: Phone    In-Person    Mail-in

Other: \_\_\_\_\_

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Received by:

Date

Tracking Number  
(E.g. 07.29.10-001)