GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

To file a complaint against a substance abuse treatment facility or program, complete the Complaint and Incident Report Form found below.

As the single state authority for substance abuse services, it is the role of the Addiction Prevention and Recovery Administration (APRA) to continuously improve the substance abuse services provided in the District of Columbia. Substance abuse treatment facilities and programs are required to adhere to District of Columbia laws and regulations governing substance abuse treatment and APRA are charged with enforcing those laws and regulations. You may file a complaint or incident report for the following:

1. You or someone you know received inadequate or improper care at a substance abuse treatment facility or program;
2. An incident occurred at a substance abuse treatment facility or program that warrants investigation; or
3. You believe a substance abuse treatment facility or program is operating without a certification (license) from APRA.

APRA will investigate your concerns based on the information that you provide. You may file an anonymous complaint. However, if you choose to file anonymously, please be as complete as possible since we will not contact you to obtain additional information.

You may send a complaint to APRA's Risk Manager and Privacy Officer at:

Keela S. Seales, Esq.
Risk Manager and Privacy Officer
Addiction Prevention and Recovery Administration
1300 First Street NE, Suite 315
Washington, DC 20002
202-727-9569 phone
202-727-1763 confidential fax
keela.seales@dc.gov

Addiction Prevention and Recovery Administration
Substance Abuse Treatment Facility/Program Complaint Form

Please type or print legibly in black or blue ink.

I. **Complainant Information**:

Last Name: _____ First Name: _____

Phone number: _____ Email address: _____

Sex: Male ☐ Female ☐ Age: ____ Room Number: ____

Are you currently receiving substance abuse services at this program? Yes ☐ No ☐
May we reveal your identity during the investigation of your complaint? Yes ☐ No ☐

II. **Substance Abuse Treatment Facility/Program**

Name: _____

Address: _____
City State Zip Code

III. **Witness (es) to the incident:**

Name(s): _____

Contact information: _____

IV. Person or entity filing the complaint or reporting the incident on client's behalf (if not client).

Name: _____ Relationship: _____

Address: _____
City State Zip Code

Phone number: _____ Email address: _____

V. **Have you reported this concern or incident to a grievance officer/or the person in charge of the facility/program?** Yes ☐ No☐

If yes, name of the person you informed and date: _____

VI. Describe the incident or your concerns. Include dates, times, locations, persons involved and a detailed description of what happened, including events leading up to the incident and any injuries (if any). You may write on the back of this form, attach additional sheets, and include attachments. If you are filing this complaint anonymously, please be as complete as possible since we will not contact you to obtain additional information.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information I have provided in support of this complaint is true and correct to the best of my knowledge. I agree to participate fully in any complaint investigation or grievance resolution process initiated by the Department of Health.

_____ _____

Signature of Complainant Date

FINDINGS AND RECOMMENDATIONS

(To be completed by Agency Unusual Incident/Grievance Officer)

VII. Review the information gathered during this investigation. Describe what occurred based on the information available, including the statements of the complainant, respondent, and witnesses, as well as any supporting information reviewed. You may attach additional sheets if necessary.

VIII. Based on the facts found in Section VI, what corrective actions will your program Implement to prevent similar incidents from occurring? You may attach additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information I have provided in the investigation of this complaint is true and correct to the best of my knowledge. I agree to participate fully in any complaint investigation or grievance resolution process initiated by the Department of Health.

_____ _____

Signature of Grievance Officer Date