

## Blair County Drug and Alcohol Complaint Form

Client Name \_\_\_\_\_

Date \_\_\_\_\_

Treatment Provider \_\_\_\_\_

**Area of Complaint:**

\_\_\_ 1. Denial or termination of services

\_\_\_ 3. Length of stay in treatment

\_\_\_ 2. Level of care determination

\_\_\_ 4. Violation of the individual's human or civil rights

**Client's concerns regarding the above are of complaint:** (if additional space is needed please attach pages to this form)

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**Date Provider notified of Complaint:** \_\_\_\_\_

**Outcome of provider's review of the above complaint:**

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**Complaint resolved:** \_\_\_yes \_\_\_no

**Provider Signature** \_\_\_\_\_

**If not resolved date referred to Single County Authority** \_\_\_\_\_