DAVID L. LAKEY, M.D.
COMMISSIONER

COMPLAINT To:

SUBSTANCE ABUSE COMPLIANCE GROUP
PATIENT QUALITY CARE, REGULATORY SERVICES
Texas Department of State Health Services

E-mail: SACG@dshs.state.tx.us
Fax: 512-834-6638

Purpose: This form is to be used by consumers (patients, clients, family members, etc.) to submit a complaint against a Substance Use Disorder treatment facility OR an Opioid Treatment Program.

I. INTAKE INFORMATION

Date: **Time:** ☐ Fax ☐ Email

Have you filed a grievance with the facility? ☐Yes ☐ No When

If we contact the facility, may we identify you as the complainant? ☐ Yes ☐ No

II. COMPLAINANT INFORMATION

Name:	Telephone Number:		
Address:	City:	State:	Zip:
E-mail:			
Are you the patient? ☐Yes ☐ No	If you are not the patient, what is your relationship:		

III. FACILITY INFORMATION

Facility Name:	Telephone Number:		
Address:	City:	State:	Zip:
Contact Person:	Title:		

IV. PATIENT INFORMATION **PATIENT ID # if applicable:** _____

Name:	Telephone Number:		
Address:	City:	State:	Zip:
E-mail:			

V. COMPLAINT: Please provide specific detailed information (who, what, when, where, and how).

Procedure: Upon receipt of this complaint, the SACG manager or team lead will screen case and assign to an investigator. All jurisdictional complaints will be acknowledged by email or phone call within 3 business days. For rules applying to SUD treatment facilities, refer to Chapter 448 in the Texas Administrative Code (TAC). For OTP rules, refer to Chapter 229 in the TAC.

VI. FOR INTERNAL USE ONLY

Case Assigned to:

Complaint Category: ☐ **#1** ☐ **#2** ☐ **#3** ☐ **Non Jurisdictional** ☐ **Technical Assistance**

☐**Abuse**	☐**Standards of Care/Service**	☐**Transportation**
☐**Neglect**	☐**Unprofessional Conduct**	☐**Medication Management**
☐**Exploitation**	☐**Confidentiality**	☐**Other**
☐**Client's Right**	☐**Physical Plant**	☐**Other**