D·B·H·D·D

Department of Behavioral Health & Developmental Disabilities

Constituent Services

INTAKE FORM

Your Information			
*First Name:	*Last Name:		
Street Address:			
City:	State:	ZIP Code:	
*Phone:	Alternate Number:		
*County:	Email:		

*Are you submitting this form on behalf of yourself or an individual? ☐ Self ☐ Individual

Relationship to Individual *(if applicable)

☐ Advocate/Friend ☐ Family ☐ Legal guardian

Individual Information *(if applicable)*			
*First Name:	*Last Name:		*Date of Birth:
Street address:			
City:	State:	ZIP Code:	County:
Phone:	Email:		

*Type of Inquiry	*Area of Concern
☐ Complaint ☐ Compliment ☐ Question ☐ Request ☐ Suggestion	☐ Substance Use ☐ Intellectual Developmental Disabilities ☐ Mental Health ☐ Human Resources ☐ Provider Network ☐ General

Provider Information *(if applicable)*			
*Provider Name:			
*Provider Address:			
City:	State:	Zip Code:	County:

- Provide a brief description of the complaint/concern or question. Include dates, names, and information that is relevant.

By signing this intake form, I authorize DBHDD and relevant DBHDD providers to discuss/disclose my personal and protected health information (via email, telephone,) to address and resolve this inquiry.

* Signature _____ *Date _____

*Individual/Legal Guardian Signature _____ *Date _____

Send the completed form to:

Mail: Georgia Department of Behavioral Health and Developmental Disabilities
Constituent Services
200 Piedmont Avenue, S.E.
West Tower, 14th Floor.
Atlanta, GA 30334-9026

Fax: 770-408-5439

Email: DBHDDConstituentServices@DBHDD.ga.gov

All inquiries and complaints will receive a response within seven (7) business days. Depending on the nature and complexity of the inquiry, additional time may be necessary to resolve. If you have any questions regarding this form please call 404.657.5964.