Department of Behavioral Health & Developmental Disabilities

Office of Constituent Services

INTAKE FORM

Please provide the information requested below. All information received will be kept confidential, except as is necessary to resolve the issue for which help is requested.

Please specify if you wish to remain anonymous. ☐ YES ☐ NO

***Required Fields**

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

*Are you submitting this form on behalf of yourself or a consumer? ☐ Self ☐ Consumer
(i.e. someone receiving or requesting services through DBHDD)

Relationship to Consumer *(if applicable)

☐ Advocate ☐ Family member ☐ Friend ☐ Legal guardian ☐ Other

Consumer Information *(if applicable)*			
*Last Name:	*First Name:		*DOB:
Street address:			
City:	State:	ZIP Code:	County:
Phone:	Email:		

*Type	*Area of Concern
☐ Complaint ☐ Compliment ☐ Question ☐ Request ☐ Suggestion	☐ Addictive Diseases ☐ Developmental Disabilities ☐ Mental Health ☐ Human Resources ☐ Provider Network ☐ Other

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-contracted providers to discuss/disclose my personal and protected health information (via email, telephone, or in person) to address and resolve this inquiry.

______________________________ ______________
* Signature *Date

______________________________ ______________
*Consumer/Legal Guardian Signature *Date

Send the completed from to:

Mail: Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD)
Office of Constituent Services
2 Peachtree Street NW, 24th Floor
Atlanta, Georgia 30303

Fax: 770.408.5439

E-mail: DBHDDConstituentServices@DBHDD.ga.gov

Once your form is received, you will be given a case number. All inquiries and complaints will receive a response within five 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 from, please call 404.657.5964, and reference the case number provided.

INTERNAL USE ONLY

Date Received: ______________	Case #: ______________	Entered CSTS: ______________
Case Manager: ______________	Region: ______________	Date Assigned: ______________
Notification sent: ______________	Mail ☐ Phone ☐	Intake Initials: ______________