To: Quality Improvement Behavioral Health Services

Grievance Form

Client Name:	**Date of Birth:**	**Today's Date:**
Current Address:		**Phone#:**
Parent / Guardian Name (if under 18 years old):		
Description of action you are grieving:		
What you would like to have happen:		

The County Mental Health Plan & Drug Medi-Cal Organized Delivery System take your concerns seriously. We will make every reasonable effort to meet your needs. You will not be subject to discrimination, or any other penalty for filing a Grievance Resolution Request Form. Information provided on this form will not become part of your medical records. It will remain in the Quality Improvement Department and will only be shared with other staff on a need to know basis in order to resolve the problem. All information pertaining to grievances will be treated as confidential information per Santa Cruz Behavioral Health Services policies and procedures. A decision about the grievance will be sent to you in writing within 30 calendar days.

What if I need help with the process?

You may authorize any other person, including a Provider, to act on your behalf regarding a grievance. A signed written consent form is encouraged if a representative is acting on your behalf.
If you have a grievance regarding mental health services, you may also contact the Ombudsman/Advocate's office for assistance at: (831) 429-1913.
If you are receiving psychotherapy services by a Board of Behavioral Sciences (BBS) licensed or registered provider, you can send a complaint regarding provided services by an AMFT / LMFT, ASW / LCSW, APCC / LPCC or licensed educational psychologist to the BBS online: www.bbs.ca.gov, or phone: (916) 574-7830.
If you have a grievance regarding substance use disorder services, you may also contact the State Department of Social Services: (800) 952-5253.

For Office Use Only

Date Received:	Date Resolved:	Resolved by:
Resolution:		