



<b>Grievance Reference ID:</b>		<b>Date:</b>	
<b>Clinic/Program/ FFS Provider Name:</b>		<b>Contact Phone:</b>	
<b>Staff Completing Response:</b>		<b>Title:</b>	
<b>Supporting Documentation Provided:</b> (check all that apply)	<input type="checkbox"/> <b>Progress Notes</b>	<input type="checkbox"/> <b>Staff Memo</b>	
	<input type="checkbox"/> <b>Chart Review</b>	<input type="checkbox"/> <b>Staff Interview</b>	
	<input type="checkbox"/> <b>Contact Logs</b>	<input type="checkbox"/> <b>Other</b>	
	<input type="checkbox"/> <b>Incident Reports</b>	<input type="checkbox"/> <b>N/A</b>	

**Grievance Response:** Please complete sections 1 through 4 below, if more space is required, continue on Grievance Investigation Supplemental Response Form and indicate which sections are being continued.

**1) Grievance Summary:**

**2) Steps taken to resolve grievance:**

**3) Grievance resolution:**

**4) Decision reasoning:**

My signature indicates that I am informed of and confirm the above response

<b>Supervisor Name Printed</b>	<b>Supervisor's Signature</b>	<b>Date</b>
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**Program Manager Initials:** \_\_\_\_\_ or  **N/A-FFS Provider**

**DISPOSITION:**

- Response sent back to [DBH-Grievances@dbh.sbcounty.gov](mailto:DBH-Grievances@dbh.sbcounty.gov) on this date: \_\_\_\_\_
- Emailed     Faxed     Interoffice Mail     Standard Mail     Delivered

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