SAN BERNARDINO COUNTY | Behavioral Health

GRIEVANCE INVESTIGATION SUPPLEMENTAL RESPONSE FORM

GRIEVANCE INVESTIGATION *SUPPLEMENTAL* RESPONSE FORM

Grievance Reference ID:		**Date:**	
Clinic/Program/FFS Provider Name:		**Contact Phone:**	
Designated Investigator:		**Title:**	
Supplemental Grievance Response related to section:	☐ 1	☐ 2	☐ 3 ☐ 4

DISPOSITION

☐ **Response sent back to DBH-Grievances@dbh.sbcounty.gov on this date: _____**

☐ **Emailed** ☐ **Faxed** ☐ **Interoffice Mail** ☐ **Standard Mail** ☐ **Delivered**