



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

CONFIDENTIAL: PLEASE NOTE THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS PRIVILEGED, CONFIDENTIAL, & PROTECTED FROM DISCLOSURE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR AN EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THIS MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED.