SAN BERNARDINO COUNTY

Behavioral Health

GRIEVANCE NOTIFICATION FORM

Complete this form if the beneficiary/client has expressed dissatisfaction regarding anything other than an NOABD.

Clinic/Program/FFS Provider Name:		**Date:**	
Clinic Supervisor:		**Contact Phone:**	
SIMON Number/ Reference ID Number:		**Contact Phone:**	

Medical Beneficiary:	☐	**YES**	☐	**NO**
Type of Service:	☐	**Mental Health**	☐	**Substance Use**
Grievance resolved by close of business next business day?	☐	**YES**	☐	**NO**
(If YES complete #1 through #3, if NO complete #1 ONLY)				

1: Summary of Grievance:				
2: Resolution: (Leave blank if not resolved within 24hr. Period)				
3:Resolved to the satisfaction of the beneficiary/client:	☐	**YES**	☐	**NO**

Please select all that apply:

- ☐ **Provided beneficiary/client grievance form.**
- ☐ **Provided beneficiary with the DBH Access Unit phone number.**
- ☐ **Beneficiary/client declined formal grievance process.**

Complete and submit to DBH Access Unit: DBH-Grievances@dbh.sbcounty.gov