



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:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Type of Service:	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Substance Use
Grievance resolved by close of business next business day?	<input type="checkbox"/>	YES	<input type="checkbox"/>	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:	<input type="checkbox"/>	YES	<input type="checkbox"/>	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

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.