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**

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