San Bernardino County
Department of Behavioral Health

ACA 1557 GRIEVANCE FORM

Form to be completed by client and emailed to ACA_1557@dbh.sbcounty.gov, or mailed to:

DBH Office of Equity and Inclusion
Attn: ACA 1557 Coordinator
303 E. Vanderbilt Way
San Bernardino, CA 92415

Client may also call the ACA 1557 Coordinator directly: Phone: (909) 252-5143, TTY: 711

Name	Date of Birth
Home Address	SSN (Last four ####)
City & Zip Code	Gender: ☐ M ☐ F ☐ Other
Phone #	Preferred language

At any time during the Grievance or Appeal processes, the complainant may authorize a person to take action or participate in the process on his/her behalf or to assist the complainant with the process.

Using authorized representative? ☐ Yes ☐ No	If “Yes”, provide their name and phone # below
Name	Phone #

Please identify the area(s) in which you feel you experienced discriminatory action(s):

☐ Race/Ethnicity	☐ Gender	☐ Age
☐ National Origin	☐ Sexual Orientation	☐ Disability

Non-discrimination rights were: ☐ not posted ☐ not included in mailings ☐ not on the website

Language Services were:
☐ not available ☐ not qualified ☐ not timely ☐ not accurate ☐ didn’t protect my privacy

ASL interpreter was:
☐ not available ☐ not qualified ☐ not timely ☐ not accurate ☐ didn’t protect my privacy

☐ Written content in paper or electronic form not available in my language

☐ Hearing and/or visual aids not available ☐ Poor quality video interpreting services

☐ Online health programs, information, and activities are not accessible to me

☐ Facility is not accessible to individuals with impaired mobility and/or blindness/low vision.

☐ Other problem

San Bernardino County
Department of Behavioral Health

ACA 1557 GRIEVANCE FORM

Date of Discriminative Action:
Please tell us about your grievance in detail:

Printed name	Signature	Date