If you need assistance with completing this form:

- You may ask any Mental Health Plan staff to assist you.

- You may call Member Services.
  (916) 875-6069

  Toll Free 1-888-881-4881
  TTY (916) 876-8853

- You may call the Patient Rights Advocate.
  (916) 333-3800

Sacramento County
Board of Supervisors
Phil Serna, 1st District
Patrick Kennedy, 2nd District
Susan Peters, 3rd District
Sue Frost, 4th District
Don Nottoli, 5th District

County Executive
Navdeep S. Gill

Department of Health Services
Peter Beilenson, MD, MPH, Director

Division of Behavioral Health
Ryan Quist, Ph.D., Behavioral Health Services Director

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Grievance

Note: Filing a grievance shall not adversely affect your services with Sacramento County Mental Health Plan. The member will be contacted by Member Services and will receive a written response within (90) ninety calendar days. Please complete this form, then fold and secure, stamp and mail.

Please print or write legibly.

Date: ____________________________  Service Location: ____________________________

Client Name: ______________________  Date of Birth: ____________________________

If client is a minor, enter the name of legal guardian filing on behalf of minor: ________________________________

Address (City/State/Zip): ________________________________

Phone Number (please indicate best time to call): ________________________________

Describe the reason(s) for requesting a grievance. Please be specific by including names, dates, and times whenever possible.

Date(s) of incident: ________________

1. Describe grievance or nature of grievance. Please attach additional pages if necessary:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Have you tried to resolve the problem(s) before requesting the grievance?

☐ Yes  Please describe what you have done to try to resolve the problem and include the results:

________________________________________________________________________

☐ No, I have not made any prior attempts to resolve the grievance.

3. What would you like to see happen to resolve this grievance?

________________________________________________________________________

I understand that I will be contacted about this request within thirty (30) calendar days

Signature of person making this grievance: ____________________________  Today’s date: ____________