

County of Santa Barbara
Mental Health Plan
Grievance

Please complete the top half of this form with the information requested and mail the entire form to:

Santa

**ADMHS Beneficiary Concerns
315 Camino del Remedio #257
Barbara, CA 93110**

Grievance: 60 days for resolution (Grievance is defined as an expression of dissatisfaction about any matter other than a matter that deals with services that have been terminated, reduced, or a change in level of care that has previously been granted. Title 9, Section 1850.205)

Date: _____

To: Beneficiary Concerns Representative

I wish to submit a grievance about: _____

for the following reasons: _____

I am willing to offer additional information by phone or in person.

My Phone: _____
Telephone **Number**

My Address: _____
Address

_____ **City** **Zip Code**

PRINT NAME: _____ **SIGNATURE:** _____

DATE OF BIRTH: _____

THE SECTION BELOW TO BE COMPLETED BY BENEFICIARY CONCERNS

Client's Name: _____

Oral grievance received by _____ Date received: _____

Grievance was reviewed on _____ by _____

Response: _____

Response was provided in writing on _____

Information on Appeal, Expedited Appeal and State Fair Hearing sent along with response? Yes No

To be sure that you receive a response, Beneficiary Concerns will send you a letter by Certified Mail. You will need to sign a receipt.