# KINGS COUNTY BEHAVIORAL HEALTH

## GRIEVANCE FORM

Date: ____________________

Provider: ______________________________________________________________________________

Name: _________________________________________________________________________________

Address: _______________________________________________________________________________

Telephone: _____________________________________________________________________________

Primary language spoken: _________________________________________________________________

Grievance:
Give a brief description of the problem (agency involved, persons to be questioned, dates, etc.)

______________________________________________________________________________________

______________________________________________________________________________________

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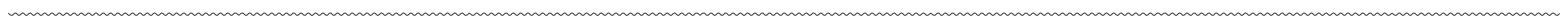
______________________________________________________________________________________

______________________________________________________________________________________

Signed: ______________________________



If you helped complete this form, please print your name: _______________________________________

What is your relationship with the consumer? ____________________________________________