

Note: Filing a grievance/complaint shall not adversely affect your services with Kings County Behavioral Health Mental Health Plan or network providers. The patient will be contacted by Patients' Rights Advocate and will receive a written response within (30) thirty calendar days. Please complete this form, then fold and secure, in self-addressed envelope 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): _____

I'd like for my information to remain anonymous.

**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 five (5) calendar days with a written Notice of Acknowledgement.

Signature of person making this grievance: _____ Today's date: _____

Submit your form

Mail: 1400 W. Lacey Blvd. Bldg. 13 Hanford, CA 93230

In Person: 1222 W. Lacey Blvd. 2nd Floor Hanford, CA 93230

Email: BHPRA@co.kings.ca.us or Fax (559) 852-4219