KINGS COUNTY behavioral health

Kings County Behavioral Health Grievance/Complaint Form

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 (90) ninety 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 thisgrievance:______________________________Today'sdate:__________

Submit your form:

Mail / In-Person:

Kings County Behavioral Health: Patients' Rights Advocate

460 Kings County Dr. Suite 101 Hanford, California 93230 | Or **Email**: BHPRA@co.kings.ca.us | Or **Fax**: (559) 584-6037