CONTRA COSTA
HEALTH SERVICES

GRIEVANCE REVIEW REQUEST

CONTRA COSTA
MENTAL HEALTH
Quality Improvement Office
1340 Arnold Dr., Suite 200
Martinez, California 94553
Ph 925/957-5160
Fax 925/957-5156

OFFICE USE ONLY
Grievance No. _____
Date Received_____

Consumers who are unable to adequately resolve a decision, complaint or who disagree with a decision, including a request for a change of provider, may file a grievance by filling out this form.
Your current Contra Costa County Mental Health services will NOT be adversely affected in any way by filing a grievance.
SEE REVERSE SIDE OF THIS FORM FOR IMPORTANT INFORMATION YOU SHOULD KNOW.
Please Print or Type

1. The following information is required to proceed with a grievance hearing: **TODAY'S DATE** _____

CLIENT NAME _____ **BIRTHDATE** _____

NAME OF LEGAL GUARDIAN IF ON BEHALF OF MINOR _____

ADDRESS _____

CITY _____

PHONE _____ **BEST TIME TO CALL** _____

2. Describe the reason(s) for filing a grievance. Be specific by including names, dates, and time whenever possible. (Attach additional sheets if necessary.)

3. Have you tried to resolve the problem(s) before filing a 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 attempt to resolve the problem(s).

4. What would you like to happen to resolve the grievance?

5. Please add anything else you would like us to know. You may attach additional pages.

SIGNATURE OF PERSON MAKING REQUEST _____ DATE _____

RETURN THIS FORM TO: QUALITY MANAGEMENT & IMPROVEMENT COORDINATOR
MENTAL HEALTH ADMINISTRATION
1340 Arnold Dr., #200, Martinez, CA 94553