



San Bernardino County
Department of Behavioral Health

For Office Use Only:
Simon #

GRIEVANCE FORM

FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO THE ACCESS UNIT

303 E. Vanderbilt Way, San Bernardino, CA 92415, 909-386-8256, Toll free 888-743-1478, TDD 888-743-1481, Fax 909-890-0353

Beneficiary Name: (Please print or write clearly) Date: Time:

Date of Birth: Gender: M F Preferred Language:

Home Address: SSN: XXX-XX-

City: Zip: Phone:

Using Authorized Representative: No Yes if yes, Name: Phone:

Clinic or Provider:

Please Tell Us About Your Grievance:

Multiple horizontal lines for writing the grievance details.

How Would You Like to See Things Resolved?

Multiple horizontal lines for writing the resolution preference.

Beneficiary Signature: Date: