



Department of Behavioral Health

For Office Use Only:

Simon #

PATIENTS' RIGHTS GRIEVANCE FORM

FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO PATIENTS' RIGHTS

850 East Foothill Boulevard, Rialto, CA 92376
(800) 440-2391 ♦ Fax (909) 421-9258

Client Name: Date: Time:
(Please print / write clearly)

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

Date of Birth: Gender: M F Preferred Language:

Home Address: SSN: XXX-XX-

City: Zip: 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: