COUNTY OF YOLO

Health & Human Services Agency
Behavioral Health

GRIEVANCE FORM

For Office Use Only:

_____
MR #

FORM TO BE COMPLETED BY *CLIENT* AND FORWARDED TO QUALITY MANAGEMENT

137 N. Cottonwood St., Woodland, CA 95695, 530-666-8788, Toll free 888-965-6647, TDD 800-735-2929, Fax 530-666-8637

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

Date of Birth: _____ **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: _____

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How Would You Like to See Things Resolved? _____

_____

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Beneficiary Signature: _____ **Date:** _____