Department of Behavioral Health

PATIENTS' RIGHTS OFFICE GRIEVANCE APPEAL FORM

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

850 East Foothill Boulevard, Rialto, CA 92376
(800) 421-4657 • Toll Free (800) 440-2391 • Fax (909) 421-9258

Client Name: _____ **Date:** _____
(Please print / write clearly)

Date of Birth: _____ **Gender:** ☐ **M** ☐ **F** **Preferred Language:** _____

Home Address: _____

City: _____ **Zip:** _____ **Phone:** _____

Alternate Phone: _____

Facility or Provider Name: _____

Using Authorized Representative: ☐ **No** ☐ **Yes if yes,**

Name: _____

Phone: _____

What is your complaint regarding the way in which your original grievance was resolved?

_____
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Once you have completed this Appeal form, an Advocate from Patients' Rights will contact you to discuss your appeal. In order to help resolve your appeal, Patients' Rights may need to discuss your concerns with other individuals. These other individuals might include your service provider, your provider's supervisor, or administrators within the Department of Behavioral Health. In order to allow Patients' Rights to discuss your appeal with these other individuals, we need to obtain your written permission to obtain information about your appeal.

Client's Signature: _____ **Date:** _____