Grievance or Appeal Form

Use this form to submit a grievance:
A grievance expresses dissatisfaction with any aspect of your treatment from Behavioral Health Services. You may fill out the information below and use the pre-addressed envelopes next to this form to submit your grievance. You may call Patients Rights' Advocacy Services at (800) 668-4240 or (866) 308-3074

☐ **Check this box If you wish to file an appeal and fill out the information below.**

Client Information

First Name:________________________ Last Name: __________________________

DOB Month:_______________ Date: ___________________ Year: _________________

Address:____

City:___________________ States: ____________________ Zip: _________________

Phone Number: ____

Program Information:

Name of program where client is receiving services.

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Street address, City, State, Zip of program of program

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Please briefly describe your concern or dissatisfaction.

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If you are completing this form, but you are not the client receiving services, what is your relationship to the client:____________________________________

Your name________________________ Your phone number________________________

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Signature of Patient or Authorized Representative **Date**