VENTURA COUNTY BEHAVIORAL HEALTH DEPARTMENT

Grievance Form

If at any point in time you are dissatisfied with the specialty mental health /substance use treatment services that you are receiving or have another concern, you may call the Quality Management Dept. at 1-888-567-2122 or you may complete this form and mail it in the addressed envelope provided.

Date: _____ Time: _____ Plan Member Name: _____

Date of Birth: _____ Gender: _____ Preferred Language: _____

Your Address: _____

Contact Phone: _____ Clinic or Provider: _____

Are you using an Authorized Representative? ☐ Yes ☐ No If yes, name: _____

Authorized Representative Phone & Address: _____

Please tell us about your grievance:

What would you like the solution to be?

_____ _____

Signature Print Name

After VCBH has received this form, a written Acknowledgment of Receipt will be sent to you within 5 calendar days. You or your authorized representative may be called on the contact phone number you have provided if more information is needed. Within 30 days you or your representative will receive a written Notice of Decision.

As a Medi-Cal beneficiary, you have the right:

- To authorize another person to act on your behalf
- To identify a staff person or other individual to assist you with the grievance
- To not be subject to discrimination or any other penalty for filing a grievance
- To identify a staff person or other individual to provide information regarding the status of your grievance
- To file a grievance orally