

County of Santa Barbara
Department of Behavioral Wellness
Grievance



Please complete this form with the information requested and mail the form to:

**Behavioral Wellness Beneficiary Concerns
5385 Hollister Ave. Bldg. #14, Box 102
Santa Barbara, CA 93111**

Grievance: 90 days for resolution (Grievance is defined as an expression of dissatisfaction about any matter other than a matter that deals with services that have been terminated, reduced, or a change in level of care that has previously been granted. Title 9, Section 1850.205)

Date: _____

To: Beneficiary Concerns Representative

I wish to submit a grievance about:

for the following reasons:

I am willing to offer additional information by phone or in person.

My Phone: _____
Telephone Number

My Address: _____
Address

City **Zip Code**

PRINT NAME: _____ **SIGNATURE:** _____

DATE OF BIRTH: _____