We try to do our best to help. If you are not satisfied with your Mental Health or Substance Use Disorder services, you can file a grievance at any time. A grievance is a complaint about any matter except a "Notice of Adverse Benefit Determination". A grievance may be filed orally or in writing by a member, a provider, or an authorized representative.

How to File a Grievance:

You may file a grievance at any time.
You can complete this form and mail it to:

Fresno County DBH
P.O. Box 45003
Fresno, CA 93718-9886

You can pick up a form and envelope at any provider site, or you may also file a grievance by calling 1-800-654-3937.
You will receive written confirmation within 5 calendar days that we received your grievance. We will send you a written decision within 30 calendar days.
If you are not satisfied with the decision and you have additional information, you may submit it for review. If you are not satisfied with the second decision, please call:

Department of Health Care Services
Office of Ombudsman
(888) 452-8609

You do not have to file a grievance with us before calling the Office of Ombudsman.

Discrimination is against the law. Fresno County Behavioral Health Plan does not unlawfully discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, sex, or other protected characteristics. We can help you with the form. We can guide you through the process. We can provide support services, such as an interpreter. If you have trouble speaking or hearing, please call 711 for help.

How to File a Discrimination Grievance:

If you receive unfair treatment based on your personal traits, you may file a discrimination grievance by calling:

U.S. Department of Health and Human Services
Office for Civil Rights
(800) 368-1019
Must file within 180 days.

California Department of Health Care Services
Office of Civil Rights
(916) 440-7370
Must file within 365 days.

Grievance Brochure/Form

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH (DBH)
1-800-654-3937

GRIEVANCE FORM (Please print clearly)

This form is used to submit a grievance, which is a complaint or concern about behavioral health services other than a decision about services.

INFORMATION ABOUT THE PERSON MAKING THE REQUEST:

Last Name:	First Name:	M.I:	This request is related to (check one): ☐ Mental Health Services ☐ Substance Use Disorder Services

Date of Birth:	Daytime Phone Number:	Message Phone Number:	Preferred Language:

Address:	Unit #:	City/State:	Zip Code:

If this request is on behalf of a minor or dependent adult, please indicate your relationship:

☐ Parent ☐ Guardian ☐ Conservator ☐ Other

Information about your Grievance:

Name of provider, program, or service involved (if known):

Date(s) of the issue or concern (if known):

Have you tried to resolve this concern already? ☐ Yes ☐ No

If Yes. Please describe what you have done to try to resolve the problem and include the results.

Description of your grievance:
(Please describe your concern. Include who, what, when, where, and why. You may attach additional pages if needed.)

Print Name:	Signature:	Date: