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".

HOW TO FILE A GRIEVANCE:

You should speak with your provider first. If this is not possible, you can complete this form and mail it to:

Fresno County
Department of Behavioral Health
P.O. Box 45003
Fresno, CA 93718-9886

You can pick up a form and envelope at any provider site.

If you do not wish to complete this form, you can call 1-800-654-3937 as another option.

You will receive a letter as soon as we receive your grievance. You will receive a decision letter within 90 calendar days.

If you are not satisfied with the decision and you have more information, you can file another grievance. 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.

You will not be discriminated or retaliated against. 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

You must file within 180 days from the day the treatment took place.

California Department of Health Care Services
Office of Civil Rights
(916) 440-7370

You must file within 365 days from the day the treatment took place.

GRIEVANCE FORM

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
1-800-654-3937

GRIEVANCE FORM (Please print)

Please select the following regarding the individual submitting the grievance: ☐ Self ☐ Family ☐ Other _____

Last Name:	First Name:	M.I	This grievance is related to: ☐ 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 you helped complete this form, please print your name:	Relationship to the person served:

Information about your Grievance:

Name of the provider/program this grievance is against:	Name of the person this grievance is against:	Date(s) of the incident:

Describe the nature of this grievance. (Be specific: Who, What, When, Where, Why, How, etc.) You may attach additional pages, if needed.

Have you tried to resolve the problem(s) before filing a grievance?
☐ Yes. Please describe what you have done to try to resolve the problem and include the results.
☐ No. What would you consider a proper resolution to this issue?

Print Name (Individual submitting grievance)	Signature (Individual submitting grievance)	Date: