County of Santa Barbara
Mental Health Plan

Grievance

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

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: _____