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UNITED STATES

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BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 61 BAKERSFIELD, CA

POSTAGE WILL BE PAID BY ADDRESSEE

KERN BEHAVIORAL HEALTH & RECOVERY SERVICES
PO BOX 1000
BAKERSFIELD CA 93302-9961



Kern Behavioral Health & Recovery Services Mental Health Plan and
Drug Medi-Cal Organized Delivery System

Grievance Form

Grievance: An expression of dissatisfaction about any matter
other than an adverse benefit determination.

Note: a grievance resolution will be made
within (30) thirty calendar days of receipt of
the grievance.



Kern Behavioral Health & Recovery Services
GRIEVANCE FORM

FORM TO BE COMPLETED BY BENEFICIARY / CLIENT AND FORWARDED TO THE PATIENTS'
RIGHTS OFFICE
PO BOX 1000, Bakersfield, CA 93302-1000
Phone (844) 360-8250

Date: _____ Service Location: _____

Beneficiary / Client
Name: _____ Date of Birth: _____ Ethnicity: _____

Gender: _____ Preferred Language: _____

If client is a minor, then name of legal guardian filing on behalf of minor: _____

Address (include City / State / Zip): _____

Phone: _____

Please print or write legibly.

Describe the reason(s) for requesting a **grievance**. Please be specific by including names, dates, and times whenever possible.

1. Describe grievance or nature of grievance.

2. What would you like to see happen to resolve this grievance?
