

If you need assistance with completing this form:

You may ask any Alcohol and Drug Services staff to assist you.

You may call Member Services.
(916) 875-6069

Toll Free 1-888-881-4 881
TTY (916) 876-8853

You may call the Patient Rights Advocate.
(916) 333-3800

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Sacramento County Alcohol and Drug Services
Quality Management, Member Services
7001A East Parkway, Suite 300M
Sacramento, CA 95823

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Sacramento County Alcohol And Drug Services

Grievance Form

Stamp
Required

Grievance

Note: Filing a grievance shall not adversely affect your services with Sacramento County Alcohol and Drug Services. The member will be contacted by Member Services and will receive a written response within (90) ninety calendar days. Please complete this form, then fold and secure, stamp and mail.

Please print or write legibly.

Date: _____ Service Location: _____

Client Name: _____ Date of Birth: _____

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

Address (City/State/Zip): _____

Phone Number (please indicate best time to call): _____

Describe the reason(s) for requesting a grievance.

Please be specific by including names, dates, and times whenever possible.

Date(s) of incident: _____

1. Describe grievance or nature of grievance. Please attach additional pages if necessary:

2. Have you tried to resolve the problem(s) before requesting the grievance?

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

No, I have not made any prior attempts to resolve the grievance.

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

I understand that I will be contacted about this request within thirty (30) calendar days

Signature of person making this grievance: _____ Today's date: _____