COUNTY OF MONTEREY HEALTH DEPARTMENT-BEHAVIORAL HEALTH MENTAL HEALTH PLAN
GRIEVANCE FORM

Date: _____
Name: _____ Date of Birth:_____
Address: _____City:_____
Zip Code: _____Telephone No:_____
Authorized Representative's Name: _____
Authorized Representative's Telephone No: _____

PLEASE EXPLAIN GRIEVANCE IN THE SPACE BELOW:
(Please include date situation occurred, persons involved and staff you have talked to about this situation)

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(please use the other side of this form if needed)

SIGNATURE **check this box if form filled in by staff** ☐