

**SANTA CLARA COUNTY MENTAL HEALTH DEPARTMENT
GRIEVANCE AND APPEAL FORM**

If you have any problems with your mental health services, you may contact a **Quality Improvement Coordinator at 1-800-704-0900** or mail this form to the Quality Improvement Program, P.O. Box 28504, San Jose, CA 95159-8504. Prepaid and pre-addressed envelopes are available.

You can also contact the **Mental Health Advocacy Project at 1-800-248-MHAP or (408) 294-9730** for additional assistance.

Please Print or Write Clearly

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Legal Guardian/Conservator: _____

Name of Agency/Staff Person Providing Service: _____

1. Describe the problem or issue: (Attach additional sheets if necessary.) _____

2. What have you already done to resolve this problem? _____

3. How would you like to see this problem resolved? _____

Client Signature _____ Date: _____