Berkeley Mental Health
Suggestion / Grievance Form

(Your services will NOT be adversely affected in any way by completing this form)

Today's Date: _____

Please check all that apply. This is a:

☐ Suggestion
☐ Complaint (grievance)
☐ Request for change of provider (My provider is: _____)
☐ Request for access to my medical records (copying fee may apply)
☐ Appeal hearing (attach complaint response letter)

Please Print. Be specific by giving names, dates and times whenever possible. You may attach additional pages if necessary.

1. **What is your complaint / suggestion/request?**

2. **For complaints/appeals only: If you have already done something to attempt to resolve your complaint, what have you done and what were the results?**

3. **What would you like to see happen?**

4. **If you would like to be contacted regarding this matter complete the information below:**

Name: _____
Address: _____ City: _____ Zip: _____
Phone: (_____) _____ - _____ Email: _____