San Francisco Health Network
Behavioral Health Services

Grievance and Appeal Form

Member Name _____ **Date of Birth** _____

Address _____**Phone**_____ **Best way to contact**_____

Type of Request (check one): ☐ Grievance ☐ Appeal ☐ Expedited Appeal (*see informational handout for definition of each type)*

My problem or concern is about the following program or provider: _____

Describe the problem or concern: _____

_____

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_____

What I would like to have happen: _____

_____

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_____

I understand that I will not be subject to discrimination as a result of filing a grievance or requesting an appeal or State Hearing.
Signature of member/legal guardian _____ Date _____
I authorize the following person to act on my behalf *(optional)* _____
Signature of authorized person if not signed by the member/legal guardian _____ Date _____

Mail the completed form in the postage-paid envelope **or** mail to the BHS Grievance/Appeal Office, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103 **or** email to BHS.GrievanceAppeal@sfdph.org