ALAMEDA COUNTY BEHAVIORAL HEALTH CARE
CONSUMER COMPLIANT FORM

Consumer's Name:	Date:
SSN:	Relationship to Consumer:
Consumer Address:	
Street Address City, State Zip	
Phone Number:	Message Phone:
Service Site:	

Description of Problem/ Compliant (Please attach additional sheet, if necessary):
What have you already done to revolve this problem?
How would you like to see this problem resolved?

Form Completed by: **Name:**	**Phone:**

DO NOT WRITE BELOW THIS LINE

To be completed by BHCS Staff

RESOLUTION TO PROBLEM/ COMPLIANT				
BHCS Staff:		PSP Number:		
Description of the Problem/Complaint Resolution:				
Consumer Contact:				
Date:	**Time:**	**☐Letter**	**☐Telephone**	**☐Other:**
Content:				
Date:	**Time:**	**☐Letter**	**☐Telephone**	**☐Other:**
Content:				
Date:	**Time:**	**☐Letter**	**☐Telephone**	**☐Other:**
Content:				
Date:	**Time:**	**☐Letter**	**☐Telephone**	**☐Other:**
Content:				