Behavioral Health Department
Alameda County Health

Karyn Tribble, PsyD, LCSW
Director

Date and Time: Click or tap here to enter text.	**Staff:** Click or tap here to enter text.	**Beneficiary Insyst #** Click or tap here to enter text.
Family: (Name/Relationship) Click or tap here to enter text.	**Authorized Representative:** Click or tap here to enter text.	**Provider:** Click or tap here to enter text.
Beneficiary's Name: Click or tap here to enter text.	**Medi-Cal #:** Click or tap here to enter text.	**MHSA funding:** ☐**Y or** ☐**N**
Address: Click or tap here to enter text. **Phone:** Click or tap here to enter text.	**Birthdate:** Click or tap here to enter text. **Medi-Cal #:**Click or tap here to enter text. **Social Security #:**Click or tap here to enter text.	
Provider Agency: Click or tap here to enter text. **Program Name:**Click or tap here to enter text.	**Time of Grievance:**Click or tap here to enter text. **Time of Grievance Resolution:**Click or tap here to enter text.	
Form of Consent: Verbal Authorization ☐**Yes** ☐**No**		**Release of Authorization Form Received:** ☐**Yes** ☐**No**
Grievance: Click or tap here to enter text.		
Grievance Resolution: Click or tap here to enter text.		

Please fax completed form to BHD Quality Assurance office 510-639-1346.