



YOLO COUNTY HEALTH & HUMAN SERVICES AGENCY

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695
Office – 530-666-8630
Fax – 530-666-8294

CLIENT GRIEVANCE FORM

You have the right to file a grievance with Yolo County Health & Human Services Agency for any dissatisfaction that you might have, except if the dissatisfaction is about receiving a Notice of Action from Yolo County Health & Human Services Agency (HHSA). If you received a Notice of Action and would like to appeal the decision given in the Notice of Action (such as a denial of mental health services), you should not use this form. If you want to appeal or complain about a Notice of Action, please ask a staff person for a Client Appeal Form.

CLIENT'S NAME: _____ MR No.: _____

Mailing Address (so that we may contact you about your grievance)

STREET ADDRESS: _____ APT. No.: _____

CITY: _____ ZIP: _____ PHONE No.: () - _____

DATE THAT THE PROBLEM OCCURRED: _____

Please describe the problem that you would like HHSA to investigate. Give as much information as you can, including who, what, where, when, and why. You may attach additional pages or write on the back of this form if you need.

When HHSA receives your completed form, a staff person will stamp it with the date. HHSA will send you a notice in writing informing you that the Agency has received your grievance and is in the process of investigating it. In most cases, HHSA will let you know what the result of your grievance is within 60 days after receiving your grievance. You will receive this result in writing.

**For more information about filing a grievance, please read the
Yolo County Health & Human Services Agency Client Problem Resolution Guide or,
contact the Quality Management Department at (530) 666-8787.**

Please send the completed form to:
Yolo County Health & Human Services Agency
Quality Management Department
137 N. Cottonwood St., Suite 2501
Woodland, CA 95695

For Office Use Only

Received by: (Staff Signature) _____ Date: _____