SUNBRIGHT RECOVERY CENTER
22425 Sunbright Avenue | Red Bluff, CA 96080
530.513.4294 | www.sunbrightrecovery.org

CLIENT GRIEVANCE FORM

For clients, former clients, family members, and authorized representatives

Your voice matters. You may file a grievance about any part of your care, treatment, staff conduct, or the facility, **without fear of retaliation**. You may type in this form and print it, or print it and write by hand. The Clinical Director will confirm receipt in writing within **5 calendar days** and send a written response within **30 calendar days**. Instructions for returning this form are on page 2.

SECTION 1 — WHO IS FILING

Client name: _____ Today's date: _____

Best way to reach you (phone or mailing address) — optional: _____

I am: ☐ The client ☐ A former client ☐ An authorized representative (family member, guardian, attorney)

If a representative — your name and relationship to client: _____

Representatives: Because client records are protected by federal law (42 CFR Part 2), we can only discuss the grievance with you if the client has signed a written authorization naming you. We can help the client complete one.

SECTION 2 — WHAT IS THIS ABOUT? (check all that apply)

☐ Staff conduct / attitude
☐ Medical / medication concern
☐ Roommate / client conflict
☐ Food / meals
☐ Facility conditions / maintenance
☐ Program rules or structure
☐ Visitation / phone / pass
☐ Discharge planning
☐ Privacy / confidentiality
☐ Discrimination or harassment
☐ Denial of rights
☐ Other (describe below)

SECTION 3 — WHAT HAPPENED?

Date(s) and time(s): _____ People involved (if known): _____

Please describe what happened, as specifically as you can (where, what was said or done, any witnesses):

SECTION 4 — WHAT WOULD RESOLVE THIS FOR YOU?

SECTION 5 — PREVIOUS STEPS

Have you already talked with staff about this? ☐ Yes ☐ No If yes, with whom? _____

SECTION 6 — SIGNATURE

Signing is optional. You may file anonymously, but we will not be able to send you a written response or contact you for more information if we do not know who you are.

_____ _____

Signature (client or authorized representative) — sign after printing Date

HOW TO RETURN THIS FORM

- **In person:** Hand it to any Sunbright staff member or directly to the Clinical Director. You may seal it in an envelope marked "Confidential – Clinical Director"; staff will deliver it unopened the same day.
- **By mail:** Sunbright Recovery Center, Attn: Clinical Director – CONFIDENTIAL, 22425 Sunbright Avenue, Red Bluff, CA 96080.
- **By phone:** Call 530.513.4294 and ask to file a grievance. Staff will write it down for you. You can also file verbally in person.
- **Please do not email this form.** Regular email is not secure, and this form contains private health information.

No retaliation. No one may punish, discharge, or change the care of a client because a grievance was filed. If you are not satisfied with our response, you may appeal to the Program Director or Executive Director within 10 calendar days.

You may contact the State at any time — you do not have to use our process first:
California Department of Health Care Services (DHCS), Licensing and Certification Division
P.O. Box 997413, MS 2601, Sacramento, CA 95899-7413
Toll-free: (877) 685-8333 | (916) 322-2911 | sudcomplaints@dhcs.ca.gov

Medi-Cal members: you may also call the member services number on the back of your Medi-Cal card.
In crisis? Call or text 988, or call 911 in an emergency.

FOR OFFICE USE ONLY

Date received: _____ Received by: _____ How received: [ ] In person [ ] Mail [ ] Phone [ ] Sealed envelope Log #: _____