SAMPLE

PROGRAM MANAGER

LEVEL I-B DECISION

[TO BE WRITTEN ON LETTERHEAD OF SERVICE PROVIDER]

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS]

Dear [CLIENT NAME]:

Your appeal of the client rights specialist’s report was received [DATE]. You and I discussed your concerns on [DATE] and were unable to establish a mutually acceptable plan for resolving your issues. This decision is my response to your complaint(s).

The issues that remain unresolved are [SUMMARY OF REMAINING CLIENT GRIEVANCES].

These grievances pertain to [LIST RIGHTS THAT RELATE TO THE COMPLAINTS].

I have reviewed your complaints and the applicable law. The following is a statement of the official position of [NAME OF SERVICE PROVIDER].

# Findings

Grievance #1:

I have determined that the client right specialist’s decision regarding your complaint about [NAME COMPLAINT] is [AFFIRMED, MODIFIED, OR REVERSED].

[IF FINDINGS WERE MOFIFIED OR REVERSED, STATE:] The reason(s) your grievance was determined to be [MODIFIED OR REVERSED] is/are [STATE REASONS].

Grievance #2:

[REPEAT ACCORDING TO THE NUMBER OF COMPLAINTS.]

# Recommendations

Grievance #1:

[STATE THE SPECIFIC ACTIONS THAT SHOULD OCCUR TO RESOLVE THE PROBLEM.]

Grievance #2:

[REPEAT ACCORDING TO THE NUMBER OF COMPLAINTS.]

[IF THE PROGRAM IS COUNTY OPERATED, COUNTY CONTRACTED, OR AUTHORIZED BY THE COUNTY, THE FOLLOWING LANGUAGE MAY BE USED:]

# Option to appeal

If you feel that this decision does not bring closure to the issues you raised and you do not wish to resolve them informally, you may appeal to the director of county department for the Level II review. The appeal must be made within 14 days of receiving this decision. Any appeal must describe the portion or portions of the decisions with which you disagree, the basis for the disagreement, and any arguments or additional information you want the county director to consider. Please send your request for a Level II review to:

[COUNTY DIRECTOR NAME]

[ADDRESS]

[EMAIL ADDRESS]

[IF THE PROGRAM IS INDEPENDENTLY OPERATED, THE FOLLOWING LANGUAGE MAY BE USED:]

# Option to appeal

If you feel that this decision does not bring closure to the issues you raised and you do not want to resolve them informally, you may appeal to the state grievance examiner at the Division of Care and Treatment Services for the Level III review. The appeal must be made within 14 days of receiving this decision. Any appeal must describe the portion or portions of the decisions with which you disagree, the basis for the disagreement, and any arguments or additional information you want the state grievance examiner to consider. Please send your request for a Level III review to:

State Grievance Examiner

Client Rights Office

Division of Care and Treatment Services

PO Box 7851

Madison, WI 53707-7851

Sincerely,

[PROGRAM MANAGER NAME]

Program Manager

cc:

[COPIES OF THIS REPORT SHOULD BE PROVIDED TO THE CLIENT, THE CLIENT RIGHTS SPECIALIST, THE PARENT, AND ALL RELEVANT STAFF.]

[\* IF THERE ARE MULTIPLE COMPLAINTS, THE STATUTORY TIMELINE (10 DAYS) FOR THE REPORT CAN BE ADJUSTED BY AGREEMENT OF THE CLIENT AND THE SERVICE PROVIDER.]