SAMPLE
PROGRAM MANAGER
LEVEL I-B DECISION:

(On Letterhead of Service Provider)
(Date)

Client's Name
Client's Address

Dear (CLIENT'S NAME):

Your appeal of the Client Right's 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 complaints(s).

The issues that remain unresolved are (SUMMARY OF CLIENT'S REMAINING 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's 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 COMPLIANTS.)

Recommendations:

Grievance #1:
(STATE THE SPECIFIC ACTIONS THAT SHOULD OCCUR TO RESOLVE THE PROBLEM.)

Grievance #2:

(REPEAT ACCORDING TO THE NUMBER OF COMPLIANTS.)

(WHERE 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
ADDRESS, FAX NUMBER

(WHERE 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 Mental Health and Substance Abuse 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 Mental Health and Substance Abuse Services
P.O. Box 7851
Madison, WI 53707-7851

Sincerely,

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.)