**SAMPLE**

**COUNTY DIRECTOR**

**LEVEL II DECISION**

[TO BE WRITTEN ON LETTERHEAD OF COUNTY]

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS]

Dear [CLIENT NAME]:

We received your appeal(s) on [DATE] regarding grievance(s) you filed about the [PROGRAM NAME]. This decision is the county level decision about your complaint(s).

The issues that remain in unresolved are [SUMMARY OF REMAINING CLIENT GRIEVANCES AND THE BASIS FOR THEM].

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

I have reviewed your complaint(s), the report of the client rights specialist, the program manager’s decision, and the applicable law. [IF THERE IS A REASONABLE CONCERN THAT THE PRIVIOUS FINDINGS ARE INACCURATE, FURTHER INQUIRY MAY BE MADE, INCLUDING PERSONAL INTERVIEWS AND INSPECTION OF EQUIPEMENT, FACILITIES, RECORDS AND OTHER MATERIALS.]

A possible solution that may not have been considered is [A PROPOSED ALTERNATIVE RESOLUTION MAY BE SUGGESTED IF DEEMED APPROPRIATE].

**Findings**

Grievance #1:

I have determined the following to be true: [LIST FACTS THAT ARE RELEVANT TO THE FIRST COMPLAINT].

I have concluded that the Level I decision regarding your complaint about [STATE THE COMPLAINT] is [FOUNDED OR UNFOUNDED].

The reason(s) your grievance was determined to be [FOUNDED OR UNFOUNDED] is/are [STATE REASONS].

Grievance #2:

[REPEAT ACCORDING TO THE NUMBER OF COMPLAINTS.]

**Recommendations**

Grievance #1:

[IF FOUNDED: STATE THE SPECIFIC ACTIONS THAT SHOULD BE CARRIED OUT TO RESOLVE THE PROBLEM.]

[IF UNFOUNDED: DISMISS THE GRIEVANCE, PENDING ANY FURTHER REQUEST FOR REVIEW (APPEAL TO LEVEL III).]

Grievance #2:

[REPEAT ACCORDING TO THE NUMBER OF COMPLIANTS.]

**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,

[COUNTY DIRECTOR NAME]

County Director

cc:

[\* COPIES OF THIS REPORT SHOULD BE PROVIDED TO THE CLIENT, THE PROGRAM MANAGER, THE PARENT/GUARDIAN, AND ALL RELEVANT STAFF (EXAMPLE: CLIENT RIGHTS SPECIALIST, STATE GRIEVANCE EXAMINER, ETC.).]

[\* 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.]