

**SAMPLE
COUNTY DIRECTOR
LEVEL II DECISION:**

(On Letterhead of County)
(Date)

Client's Name
Client's Address

Dear Client:

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 complaints(s).

The issues that remain in unresolved are (SUMMARY OF CLIENT'S REMAINING GRIEVANCES AND THE BASIS FOR THEM).

These grievances pertain to (LIST RIGHTS THAT RELATE TO THE COMPLAINTS).

I have reviewed your complaints, the report of the Client Rights Specialist, the Program Manager's decision and the applicable law. (IF THERE IS A REASONABLE CONCERN THAT THE PRVIOUS FINDINGS ARE INACCURATE, FURTHER INQUIRY MAY BE MADE, INCLUDING PERSONAL INTERVIEWS, 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.)

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 COMPLAINTS.)

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,

County Director

cc: Client
Program Manager
Client Rights Specialist
State Grievance Examiner

(* 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.)

(* COPIES OF THIS REPORT SHOULD BE PROVIDED TO THE CLIENT, THE PROGRAM MANAGER, THE PARENT/GUARDIAN AND ALL RELEVANT STAFF.)