

Staff to fill out this side.

LEVEL 1 RESPONSE

Please print

Patient Name: _____ **Unit:** _____

Date Unit Rcvd: _____ **Grievance #:** _____

Consumer & Family Box
Database ID #:

Avatar #: _____

Emergency Grievance: Date called or sent to Chair of Grievance Committee: _____
Date → Chair ruled out: _____ Chair will provide written response ✓: _____

Sent to OAAPI: Date sent : _____ Date response received: _____

✓ OAAPI Decision: Ruled out: ___ (Unit to Handle as Level 1.)
Investigating: ___ (No further grievance action is required.)

Civil Rights: Date called or sent to Chair of Grievance Committee: _____

Date → Chair ruled out: _____ Chair will provide written response ✓: _____

✓ Title VI: _____ Section 504: _____ ADA: _____ Protected class: _____

Level 1 Treatment Team Response : _____ **Date of Review:** _____

IDT members present: _____

Others Present: _____

Findings of Fact: _____

Resolution: _____

Patient Satisfied with resolution: Patient
✓ ___ YES ___ NO Signature: _____

✓ if Patient declined to meet: ___ ✓ if Patient declined to sign: ___

Form completed/submitted by: _____ Completion Date: _____

Please print

Distribute a completed two-sided copy to each of the following:

Patient –Treatment Team - Program Director – Superintendent - Grievance Committee - Representative (if applicable)