DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ADULT MENTAL HEALTH SERVICES

Level 1 GRIEVANCE REPORTING FORM

Today's Date:______________________________

Your Name:____

Address:____

____

Phone/TTY:____

Name of Agency/Service Provider Involved: __________________________________

____

Location of Service Provider: (Town/City):___________________________________

____

Date(s) that the incident happened:____

Name(s) of People Involved: ____

____

____

Please Briefly Describe What Happened: (use the back of this form if necessary.)

What is the specific issue that needs to be addressed?

How can this matter be resolved?