SACRAMENTO COUNTY
Adult Correctional Health

**Grievance Appeal** (Please check one) **Grievance No. _____**

☐ **First Level** ☐ **Second Level**

**Grievance Type:** (Please check one)

☐ **MEDICAL** ☐ **MENTAL HEALTH** ☐ **DENTAL** ☐ **DISABILITY**

**Name _____ XREF No. _____ Today's Date _____**

| **Reason for Appeal** |
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**Name _____ XREF No. _____ Today's Date _____**

| Describe the Reason for the Decision Reached |
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| **DOES GRIEVANCE MEET ADA CRITERIA? ☐ Yes ☐ No** | | | |
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| Reviewed by | | Date of review | |
| **Met with Patient ☐ Yes ☐ No (If "Yes," provide date, time and location of meeting below)** | | | |
| Location | | Date and time | |

| **RESOLUTION** | |
|---|---|
| Approved ☐<br>Denied, appeal form provided ☐<br>Withdrawn ☐ Yes ☐ No<br>Out of Custody ☐ | Patient Signature:<br><br>Healthcare Provider Signature: |
| Copy given to Patient ☐ Yes ☐ No | Effective Communication Used Yes ☐ No ☐ |
| Date: | Summary of findings given to QI Compliance Team |