SACRAMENTO COUNTY
Adult Correctional Health

Grievance Form

Grievance No. ____________

Grievance Type: (Please check one)

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

Name ________________________________ **XREF No.** ___________ **Today's Date** _________

IF YOU ARE HAVING A MEDICAL OR PSYCHIATRIC EMERGENCY NOTIFY AN OFFICER

Attach Tape

DO NOT WRITE IN THIS AREA

Statement of Grievance
Date of Incident:
Explain in detail your complaint below:

Name ________________________________ **XREF No.** ___________ **Today's Date** _________

Investigation Summary – ACH STAFF ONLY
Instructions: Document face-to-face meeting with inmate, chart review, and resolution.

DOES GRIEVANCE MEET ADA CRITERIA? ☐ **Yes** ☐ **No**			
Reviewed by		Date of review	
Met with Inmate ☐ **Yes** ☐ **No** **(If "Yes," provide date, time and location of meeting below)**			
Location		Date and time	

RESOLUTION	
Approved ☐ Denied, appeal form provided ☐ Withdrawn ☐ Yes ☐ No	Patient Signature: Healthcare Provider Signature:
Copy given to Patient ☐ Yes ☐ No	Effective Communication Used Yes ☐ No ☐
Summary of findings given to Compliance Officer ☐ Yes ☐ No	Name of Officer: Date:

***Second Level Review is needed if grievance is not resolved or if operational changes are needed.**