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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02925 (01/2022) | | | | **STATE OF WISCONSIN** | | | | | | | | |
| **REQUEST FOR HIV CARE GRIEVANCE RESOLUTION WISCONSIN COMMUNICABLE DISEASE HARM REDUCTION SECTION HIV CARE UNIT**  **INSTRUCTIONS:** To begin the grievance process, complete sections 1 and 2 of this form, sign, and submit as explained in section 3. Attach additional pages and documentation as needed. If the grievance is subsequently resolved, sign section 4 and resubmit. | | | | | | | | | | | | |
| **SECTION 1: GRIEVANT INFORMATION** | | | | | | | | | | | | |
| I,       , am requesting resolution of a complaint filed under the Department of Health Services Communicable Disease Harm Reduction Section’s grievance procedures for HIV care. | | | | | | | | | | | | |
| Name (First and last) | | Preferred name | | | | | | Pronouns | | | | Date of birth |
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| Phone number | | | | I consent to allow DHS staff to contact me about this grievance at this phone number | | | | | | | | |
| Email | | | | I consent to allow DHS staff to contact me about this grievance at this email (***Please note that emails may not be a secure form of communication*** | | | | | | | | |
| Mailing address | | | | I consent to allow DHS staff to contact me about this grievance at this address | | | | | | | | |
| **SECTION 2: DETAILS OF GRIEVANCE** | | | | | | | | | | | | |
| Agency and/or individual(s) grievance against | | | | Agency’s address (street and number, city, state, and ZIP code) | | | | | | | | |
| Date, time, and location of event | | | | Witnesses to event (if applicable) | | | | | | | | |
| Please provide a detailed account of the complaint. Include names of all involved. (Attach additional pages if needed) | | | | | | | | | | | | |
| Please provide any policies, guidelines, or procedures you believe have been violated. (Attach additional pages if needed) | | | | | | | | | | | | |
| Please describe the outcome you would like to resolve the complaint. (Attach additional pages if needed) | | | | | | | | | | | | |
| **SIGNATURE** — Grievant | | | | | | | | | | Date Signed | | |
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| **SIGNATURE** — DHS Staff Receiving Grievance | | | | | | | | | | Date Signed | | |
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| **SECTION 3: INSTRUCTIONS FOR SUBMITTING THIS FORM** | | | | | | | | | | | | |
| 1. Submit the original of this form and copies of any supporting documentation. In most cases, you will submit this form to the agency that provided the service. See the Client Grievance Policy for details. 2. If this is an appeal of an agency decision or involves an incident that can be submitted directed to the state, submit this form to: **Ryan White Program Coordinator, Wisconsin Division of Public Health, Wisconsin CDHR, Room 230, 1 W Wilson, Madison WI 53701-2659**. The form can also be submitted using email to [**DHSRWFeedback@wi.gov**](mailto:DHSRWFeedback@wi.gov). Please see [P-03184](https://www.dhs.wisconsin.gov/publications/p03184.pdf) Grievance Policy for Ryan White Part B and Mike Johnson Services for details. **Please be aware that information sent via email might not a secure method of sending private or sensitive information.** 3. Maintain a complete copy for your personal records. | | | | | | | | | | | | |
| The Federal Privacy Act (5 USC 552a, subd. (3)) requires this notice to be provided when collecting personal information from individuals. This information requested on this form is requested by the Wisconsin Department of Health Services, CDHR, for purposes of identification and assisting us as we work to solve the problem you are contacting us to help you with. Furnishing the information on this form is voluntary. If you do not provide all the information requested on this form, we will still try to assist you in solving your problem, but the missing information may delay or prevent us from solving the problem. The information request on this form is used to identify who you are and what assistance we may provide to you, and to identify any obstacles that have delayed or prevented that assistance from being given.  This information may be disclosed to CDHR contractors and providers if this is necessary or helpful as we work to address and resolve your concern. You have the right to review your own personal information maintained by the Wisconsin Department of Health Services unless access is exempted by law. You may request your own personal information by contacting the Wisconsin Department of Health Services at Room 230, 1 West Wilson, Madison, WI 53701-2659. | | | | | | | | | | | | |
| **SECTION 4: RESOLUTION** | | | | | | | | | | | | |
| This grievance was resolved in a satisfactory manner and I release all current and future claims on this matter. | | | | | | | | | | | | |
| Name of Grievant | | | | | **SIGNATURE** – Grievant | | | | | | Date Signed | |
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| **SECTION 5: WISCONSIN CDHR USE ONLY** | | | | | | | | | | | | |
| Received at       (location) | | | | | | Received on       (date) | | | | | | |
| **PROGRESS OF THIS GRIEVANCE THROUGH THE APPEAL AND RESOLUTIONS PROCESS:** | | | | | | | | | | | | |
| Date | Progress Note | | | | | | | | | | | |
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| Date | Progress Note | | | | | | | | | | | |
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| Date | Progress Note | | | | | | | | | | | |
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| **RESOLUTION PLAN** | | | | | | | | | | | | |
| To be completed by the HIV Services Coordinator in collaboration and agreement with the individual filing the grievance. A copy is provided to the individual filing the grievance and the individual(s)/agency identified in the grievance report. The HIV Services Coordinator will keep a record of the Resolution Plan. | | | | | | | | | | | | |
| Resolution Plan Summary | | | | | | | | | | | | |
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| Action Steps: Provide specific action steps in chronological order to achieve the resolution of the complaint. List individuals involved and a proposed timeline. Attach extra sheets if needed. | | | | | | | | | | | | |
| Action Step | | | Responsible Person(s) | | | | Deadline | | Comments | | | |
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