



Milwaukee County DHHS-BHS
Children's Community Mental Health Services and Wraparound Milwaukee

Grievance and Appeals Form

Today's Date: _____

To be completed by any individual (such as a youth, parent/guardian, other family member, provider, etc.) who would like to file a grievance or appeal.

- If you need any assistance to complete the form, please contact: Client Rights Specialist at (414) 257-7600, option 1.
- If more space is needed to document your grievance/appeal, please use the Additional Information Section.
- Following your completion of this form, please submit to Children's Community Mental Health Services and Wraparound Milwaukee Quality Assurance Department (see contact information below).

_____ Name of Person/Agency filling Grievance/Appeal		Check your association with our program:	
		<input type="checkbox"/> Youth/Enrollee	<input type="checkbox"/> Parent/Guardian
		<input type="checkbox"/> Other family member	<input type="checkbox"/> Provider
_____ Street Address, City, State, Zip Code (of person filing grievance/appeal)		_____ Phone number (of person filing grievance/appeal)	
_____ Name of associated Youth/Enrollee		_____ If a grievance, list the name of Person/Agency the grievance is against	

A. Please describe your grievance or appeal. Include details, such as dates, times and individuals involved.

B. If this is a grievance, what have you done in an attempt to resolve the issue (i.e. discuss with the Provider, Care Coordinator, Supervisor, and/or Child & Family Team, etc.). Please explain.

C. What would you like to see happen about this grievance/appeal? How would you like the issue resolved?

D. Additional Information?

Signature of Person Filing the Grievance/Appeal _____ Date _____

Following the completion of this form, please submit to:

<p>Mail: Milwaukee County- DHHS Attn: Wraparound Milwaukee, Quality Assurance 1220 W Vliet St, Room 300 Milwaukee WI, 53205</p>	<p>Fax: 414-257-7575 Attn: QA Department</p> <p>Email: wrapqa@milwaukeecountywi.gov</p>
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ATTENTION: If you speak English, language assistance services are available to you free of charge. Call your Care Coordinator directly or call 1-833-912-2468 (TTY: 711)

Español (Spanish) - ATENCIÓN: Si habla español, tenemos servicios de asistencia lingüística disponibles de forma gratuita. Llame a su coordinador de atención directamente o bien llame al 1-833-912-2468 (TTY: 711)

Hmoob (Hmong) - CEEB TOOM: Yog koj hais lus Hmoob, muaj cov kev pab txhais lus pub dawb rau koj. Hu xov tooj ncaj nraim rau koj tus Neeg Khiav Hauj Lwm Muab Kev Kho Mob los yog hu rau 1-833-912-2468 (TTY: 711)

မြန်မာစာ (Myanmar) (Burmese) - အထူးသတိပြုရန် - အကယ်၍ မြန်မာဘာသာစကားကို သင်ပြောဆိုနိုင်ပါက ဘာသာစကားဆိုင်ရာ ဝန်ဆောင်မှုများကို အခမဲ့ သင် ရရှိနိုင်ပါသည်။ သင့် စောင့်ရှောက်မှု ဆက်စပ်ဆောင်ရွက်ပေးသူ ထံသို့ တိုက်ရိုက် ဖုန်းခေါ်ဆိုပါ သို့မဟုတ်လျှင်လည်း 1-833-912-2468 (TTY: 711) သို့ ခေါ်ဆိုပါ။

Chinese注意：如果您使用中文，那么您可以免费获得语言协助服务。请直接联系您的护理协 调员，或致电 1-833-912-2468 (TTY: 711)。