#008 - Complaint and Grievance Process

**POLICY**

It is the policy of Wraparound Milwaukee that any party or enrollee or his/her authorized representative (Provider or Estate Representative who has documented consent by the enrollee) who is dissatisfied with a policy, procedure, benefit, care or service has a right to seek resolution through the Wraparound Milwaukee Complaint and Grievance Process. The policy follows guidelines established by the Department of Health Services (DHS) Chapter 94 Patient Rights and Resolution of Patient Grievances.

The purpose of this Wraparound Milwaukee Complaint and Grievance Policy and Procedure is to provide a timely means to resolve complaints and grievances, to educate enrollees or representatives about appropriate use of the Wraparound Milwaukee program and to use enrollee and provider suggestions to improve Wraparound Milwaukee.

Note: An enrollee, family, advocate or staff person assisting an enrollee/family will not face any negative reproach if they initiate an informal or formal complaint or grievance.

**PROCEDURE**

Enrollees are provided with a Wraparound Milwaukee Enrollee/Family Handbook and the Wraparound Milwaukee Client Rights and Complaint/Grievance Procedure handout that outlines Wraparound Milwaukee's complaint/grievance process.

For the purpose of definition, the following applies:

- **Complaint** - Any party's dissatisfaction with any aspect of service provision, lack of service provision, policy and procedure or benefit that is expressed verbally or in writing.

- **Grievance** - Any enrollee's or enrollee's representative's written or verbal dissatisfaction with the outcome of a complaint. The grievance process is a formal procedure with specific date, time and procedural requirements.

A. Procedure Regarding Informal/Formal Complaints

1. Informal and Formal Procedure

   a. **Informal** - All parties are encouraged to initially attempt to resolve conflicts or concerns in an "informal" manner. This means initiating a discussion with the individual(s) with whom the conflict or concern has arisen. A Child & Family Team meeting should be held if necessary and appropriate. Efforts should be taken to come to a resolution prior to the complaint/formal grievance process being initiated. Enrollees are also able to get issues resolved with
Wraparound Milwaukee Administrative assistance without going through the formal, written complaint process.

Note: The complainant has the right to file a complaint at any time if he/she believes resolution cannot be achieved through the "informal" process.

b. Formal - If resolution cannot be achieved at the informal level, then the complainant may contact the Wraparound Milwaukee Quality Assurance Department at (414)257-7595 to make an inquiry or file a complaint, or they may complete a COMPLAINT/SUGGESTION FORM (Attachment 1 & 1A Spanish) and submit it to the Wraparound Milwaukee Quality Assurance Department. Complaints should be filed within 45 days of becoming aware of the concern. Extensions of this time frame may be granted.

2. Upon receiving the complaint, the Wraparound Milwaukee Quality Assurance Director (or designee) will review the information, speak with all/any necessary parties and complete the investigation, or forward the complaint to another identified investigator for follow up.

3. All attempts will be made to initially respond to the complainant within ten (10) business days, with a final response or report determining the outcome (i.e.: substantiation or unsubstantiation) to be completed within thirty (30) days from the date the complaint was received. If the complaint is identified as "critical" in nature, then all efforts will be made to initially respond and resolve the issues within two (2) working days or sooner, if possible.

4. When the Complaint Outcome results in a decision adverse to an enrollee (youth or family), the enrollee and/or his authorized representative will be advised of their right to submit a verbal or written grievance to the Wraparound Milwaukee Quality Assurance Department. A written grievance may be submitted in any form. However, it is suggested that the Wraparound Milwaukee GRIEVANCE INITIATION (Attachment 2) form be used and information relevant to the situation be submitted along with the grievance.

B. Procedure for Formal Written/Verbal Grievances

1. When a written/verbal grievance is received at Wraparound Milwaukee, the letter/contact will be date-stamped then logged onto the GRIEVANCE RECORD (Attachment 3). A written GRIEVANCE ACKNOWLEDGEMENT (Attachment 4) will be provided to the person submitting the grievance within five (5) business days of its receipt.

2. All grievances will be investigated by the Wraparound Milwaukee Program Director (or designee) (Program Director Review Level). The decision makers responsible for reviewing a member's grievance or appeal must not have participated in prior decision making.

3. Issues requiring clinical judgment and perceived quality of care grievances may be investigated by a Clinical Director or Care Coordination Supervisor from a contract agency that is not directly involved in the complaint.

4. As necessary, additional medical or other pertinent information will be sought by Wraparound Milwaukee staff.

5. When the investigation is completed and information is gathered, a Grievance Hearing will be held to review the grievance. The Grievance Hearing is to be scheduled within ten (10) days of receipt of the grievance. The Grievance Hearing will include the Program Director (or designee), the enrollee's Care Coordinator and his/her Supervisor (as applicable), and the enrollee/parent(s)/legal guardian/caregiver who may invite an advocate or other representative(s). In addition, the grievant may present evidence both orally and in writing related to their appeal and may have access to any records related to the issue being appealed (within the restrictions of the laws of Wisconsin).
The Wraparound Milwaukee Program Director can invite others (i.e., specialty providers, legal counsel, etc.), as appropriate.

6. A Grievance Hearing will be scheduled and the enrollee/parent(s)/legal guardian/caregiver will be notified verbally and in writing by a GRIEVANCE HEARING NOTIFICATION (Attachment 5) at least seven (7) calendar days in advance of the Hearing and will be informed of the date, time and location of the Hearing. The enrollee/parent(s)/legal guardian/caregiver or the enrollee’s representative may attend the Grievance Hearing and present oral and/or written information in support of the grievance.

7. Within thirty (30) calendar days of receipt of the initial grievance, the grievant will be notified of the decision or action, by a GRIEVANCE HEARING DECISION letter (Attachment 6), except as noted in Section D below. A copy of the letter will also be sent to the Care Coordinator (as applicable). This letter must include the resolution and date of the appeal resolution.

8. The decision will be logged onto the GRIEVANCE RECORD (Attachment 3).

C. Extensions to Resolve Grievances

Normally, Wraparound Milwaukee will resolve a grievance within thirty (30) calendar days of receipt of the written grievance. The time period may be extended an additional fourteen (14) calendar days if the Investigator requires more time to complete the investigation. If additional time is required, the grievant will be notified in writing by a GRIEVANCE REVIEW – 14 DAY EXTENSION (Attachment 7) that the grievance has not been resolved, when the resolution is expected and why the additional time is needed.

D. Urgent Care/Expedited Grievances

1. Urgent Care/Expedited Grievances are defined as situations where the denial of services or referral for service could result in illness or injury or where delay in care or treatment would jeopardize the enrollee's health or may result in disability. The process for requesting a verbal or written expedited grievance requires a medical provider to verify that a delay can be a health risk.

2. When this grievance is received, the letter will be date-stamped and logged onto the GRIEVANCE RECORD (Attachment 3).

3. If necessary, immediate additional information to resolve the matter will be sought.

4. Within two (2) business days of the written or verbal expedited grievance, the Wraparound Milwaukee Program Director will meet with Wraparound Milwaukee relevant staff to review the available information and render a decision. No extensions will be possible. The grievant will be notified of the Grievance Hearing as soon as possible and may attend to present oral or written information.

   Note: The enrollee has the right to present evidence and allegations of fact or law in person, as well as in writing, and may examine the member case file or any other documents and records (within the constraints of the law), but will be orally informed that this right may delay the resolution of the expedited process.

5. This decision will be immediately communicated, first verbally, then in writing, to the grievant.

6. If a request for an Urgent Care/Expedited resolution is denied by Wraparound Milwaukee, then the following will occur:

   a. The request will be transferred to the standard time frame of no longer than thirty (30) days from the date of receipt, with a possible fourteen (14) day extension.

   b. Reasonable efforts must be made to orally inform the grievant immediately of the denial and a written denial notice must occur within two (2) calendar days.
E. Reduction or Denial of a Covered Service Grievance

If the formal written or verbal grievance is regarding a reduction or denial of a covered service, and the recipient files it with either Wraparound Milwaukee, the County or the State of WI Department of Administration-Division of Hearings & Appeals within forty-five (45) days of the decision to reduce or deny benefits, the following provisions apply:

1. If the recipient was not receiving the service prior to the reduction or denial, Wraparound Milwaukee does not have to provide the benefit while the decision is being appealed. If Wraparound Milwaukee's denial, limitation, reduction, termination or suspension of services is overturned or reversed by the County or the Division of Hearings & Appeals, Wraparound Milwaukee must authorize or provide the disputed services promptly and as expeditiously as the enrollees' mental health condition requires.

2. If Wraparound Milwaukee authorized and paid for this service prior to the decision, Wraparound Milwaukee must continue to provide the same level of service while the decision is in appeal. However, Wraparound Milwaukee may require the recipient to receive the service from within the Provider Network, if medically necessary and appropriate care can be provided within the network.

Note: Recipients must grieve to Wraparound Milwaukee, the County or the Division of Hearings & Appeals within forty-five (45) days of a reduction or denial of a service.

F. Procedure for County, State of Wisconsin (WI) DHS and State of WI Department of Administration-Division of Hearings & Appeals State Review

If the decision achieved through the Program Level formal grievance process is adverse to the grievant, then he/she may appeal the decision in writing to Milwaukee County Behavioral Health Division (BHD) Administrator, and/or may proceed to any other State Level of grievance or appeal that he/she desires. The appeal to the County should be made within fourteen (14) days of the date that the Program's decision was received. County Review appeals should be addressed to:

Milwaukee County DHHS, Behavioral Health Division
Attn: BHD Administrator
9455 Watertown Plank Rd.
Milwaukee, WI 53226

If the County's decision is adverse to the grievant, or if the grievant wishes to proceed directly to the State level, he/she may appeal directly to the State of WI DHS. The appeal to DHS must be filed within (fourteen) 14 days of the date that the County's decision was received.

For assistance with filing a grievance/appeal to DHS, the enrollee (or representative) can contact Medicaid / BadgerCare Plus Ombuds at 1-800-760-0001. Ombuds will answer your questions, look into your complaints and help you file an appeal with DHS.

The enrollee (or representative) may also bypass all previous routes outlined and file a grievance or appeal directly with the State of WI Department of Administration-Division of Hearings & Appeals (Fair Hearing) by writing to:

Department of Administration – Division of Hearings & Appeals
P.O. Box 7875
Madison, WI 53707-7875
Fax: (608)264-9885

G. Interpreter Services

If needed, Interpreter Services (for non-English speaking persons and persons with hearing impairments) will be made available through Wraparound Milwaukee during the complaint and grievance process.
COMPLAINT/GRIEVANCE REVIEW GUIDELINES

A. Any individual assigned to conduct a Complaint/Grievance investigation shall not have had any involvement in the conditions or activities forming the basis of the enrollee or family’s complaint/grievance, or have any other substantial interest in those matters arising from his/her relationship to the program or client, other than employment.

B. Members of any Grievance Review/Appeal Committee may not have been involved in any prior decision-making capacity regarding the basis of the grievance.

CONFIDENTIAL FILES

A confidential file of each grievance, additional information, records of proceedings and decisions will be maintained for 5 years from the date of the last decision that was reached.

RECORD CLASSIFICATION/REPORTING

A. Each grievance that is received will be logged onto the GRIEVANCE LOG (Attachment 8), which will be maintained by the Program Director (or designee).

B. A report on current or past grievance history will be prepared on 15 days notice.

COMPLAINTS AND GRIEVANCES MADE TO PROVIDERS AND ADMINISTRATIVE SERVICES

A. Any complaint that is made or grievance that is sent to a Wraparound Milwaukee Provider or Administrative Service will be forwarded immediately to the Wraparound Milwaukee Quality Assurance Director (or designee). This provision will be included in any contract or agreement entered into with Wraparound Milwaukee.

B. When a complaint or grievance is forwarded by a Provider or Administrative Service to Wraparound Milwaukee, the complaint/grievance process as described in Section II, A2-F will be followed.

SUMMARY OF TIME FRAMES FOR COMPLAINTS AND GRIEVANCES

A. Complaint or grievance filed.

B. Notification of Receipt of complaint or grievance will be sent to complainant/grievant within ten (10) or five (5) days, respectively, of Wraparound Milwaukee's receipt of complaint or grievance.

C. If complaint, the final decision will be made and sent to complainant within thirty (30) days of Wraparound Milwaukee's receipt of complaint.

D. If grievance, a Grievance Hearing will be scheduled within ten (10) days of receipt of the grievance.

E. Grievant (other than Urgent Care/Expedited) must get seven (7) days advance notice of the scheduling of the Grievance Hearing.

F. If Urgent Care/Expedited Grievance, a Grievance Hearing will be held and a decision made within two (2) days of Wraparound Milwaukee's receipt of grievance.

G. Grievant is notified of the decision within thirty (30) days of the receipt of the grievance unless
Wraparound Milwaukee notifies the grievant of the need for a fourteen (14) day extension.

H. All grievances will be resolved within forty-five (45) days of Wraparound Milwaukee’s receipt of the grievance.

REFERENCES

1. DHS 94 – PATIENT RIGHTS AND RESOLUTION OF PATIENT GRIEVANCES
(http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/94.pdf)

Attachments:

1. Complaint/Suggestion Form
1A. Complaint/Suggestion Form (Spanish)
2. Grievance Initiation
3. Grievance Record
4. Grievance Acknowledgement
5. Grievance Hearing Notification
6. Grievance Hearing Decision
7. Grievance Review - 14 Day Extension
8. Grievance Log

Approval Signatures

<table>
<thead>
<tr>
<th>Step Description</th>
<th>Approver</th>
<th>Date</th>
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<td></td>
<td>Michael Lappen: 11008000-BHD Administrator</td>
<td>12/20/2017</td>
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<td>MaryJo Meyers: 11003003-Director Wraparound Program</td>
<td>12/20/2017</td>
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<td>Pamela Erdman: 12008005-Placement Resources Manager</td>
<td>12/19/2017</td>
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<td>Heidi Ciske-Schmidt: 12008018-Manager- Quality Assurance</td>
<td>12/19/2017</td>
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WRAPAROUND MILWAUKEE
COMPLAINT/SUGGESTION FORM

SECTION 1: To be completed by any individual (i.e., youth, parent/guardian, other family member, provider, etc.) who would like to report a complaint or make a suggestion about any aspect of the Wraparound Milwaukee program.

- If you need any assistance to complete the form, please contact Wraparound Milwaukee Quality Assurance at (414)257-7595.
- If more space is needed to document your grievance/concern, please use Page 2 of this form.
- Following your completion of this form, please submit to Wraparound Milwaukee Quality Assurance Department (see contact information below).

Check your association with Wraparound:

☐ Youth/Enrollee ☐ Parent/Guardian ☐ Other family member ☐ Provider

Name of Person/Agency Filing the Complaint/Suggestion

Street Address, City, State, Zip Code (Person Filing the Complaint/Suggestion)

Phone Number (Person Filing the Complaint/Suggestion)

Name of associated Wraparound Youth/Enrollee

If a complaint, list the name of the Person/Agency the complaint is against

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

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

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

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C. What would you like to see happen about this complaint/suggestion? How would you like to see this issue resolved?

____________________________________________________________

_________________________________________________________________________________________________________________

____________________

Signature of Person Filing the Complaint/Suggestion Date

Following the completion of this form, please submit to:

Mail: Wraparound Milwaukee Attn: Dana James
9455 Watertown Plank Road Phone: (414)257-7595
Milwaukee, WI 53226

Fax: (414)257-7575 Attn: Dana James
Email: dana.james@milwaukeecountywi.gov

Phone: (414)257-7595

Revised: 12/2017
CONTINUE - SECTION 1: To be completed by any individual (i.e., youth, parent/guardian, other family member, provider, etc.) who would like to report a complaint or make a suggestion about any aspect of the Wraparound Milwaukee program.

- If more space is needed to document your grievance/concern, please use this page (Page 2).

Additional Information:

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Signature of Person Filing the Complaint/Suggestion

Date

Following the completion of this form, please submit to:

Mail: Wraparound Milwaukee
     Attn: Dana James
     9455 Watertown Plank Road
     Milwaukee, WI 53226

Fax: (414)257-7575

Email: dana.james@milwaukeecountywi.gov

Phone: (414)257-7595

Revised: 12/2017
FORMA DE QUEJA / SUGERENCIA

Seccion 1 - Debe ser completado por cualquier individuo que quiere reportar una queja o hacer una sugerencia sobre cualquier aspecto del programa Wraparound Milwaukee (i.e., Familias, Proveedores, etc.).

- Por favor llame Wraparound Milwaukee Quality Assurance al (414)257-7595 para la asistencia.
- Por favor utilice la parte de atrás de la forma o una hoja adicional si necesita más espacio (Pagina 2)
-Enviar a Wraparound Milwaukee Quality Assurance Department (vea abajo).

Nombre de la Persona/de la Agencia llenando la Queja/Sugerencia
¿Cuál es tu asociación con Wraparound?
☐ Joven  ☐ Padre/Proveedora de Cuidados  ☐ Proveedor

Nombre de la persona/joven matriculada en Wraparound Si es una Queja, Nombre de la persona o Agencia de quien es la queja

Dirección, Ciudad, Estado, Código Postal (Persona llenando la Queja/Sugerencia)
Numero de Teléfono (Persona llenando la Queja/Sugerencia)

A. Detalles de la queja o sugerencia. Por favor sea específico incluyendo nombres, días, etc., cuando es aplicable.

________________________________________________________________________

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B. Si esto es una Queja, ¿qué ha hecho usted en una tentativa de resolver su preocupación? Incluya por favor con quien usted ha hablado y el resultado de la conversación. ¿El equipo de la familia y el niño hablaron acerca de las preocupaciones?

________________________________________________________________________

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C. ¿Qué usted quiere que ocurra como resultado de su queja o sugerencia?

________________________________________________________________________

________________________________________________________________________

Firma de la persona que completo este formulario

Enviar a: Wraparound Milwaukee
Attn: Dana James
9455 Watertown Plank Road
Milwaukee, WI 53226
Fax: (414)257-7575  Atención: Dana James
Email: dana.james@milwaukeecountywi.gov
Teléfono: (414)257-7595
Continuar - Sección 1 - Debe ser completado por cualquier individuo que quiere reportar una queja o hacer una sugerencia sobre cualquier aspecto del programa Wraparound Milwaukee (i.e., Familias, Proveedores, etc.).
- Por favor utilice la parte de atrás de la forma o una hoja adicional si necesita más espacio.

Información Adicional:

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Name of Child/Family: ________________________________

Care Coordinator/Provider: ____________________________

A. Grievance Description - Include details, such as dates of relevant events, names, addresses and phone numbers of all parties:

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B. Desired Resolution:

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C. Please check ONE of the following:

☐ I request a meeting/hearing to discuss and try to resolve above grievance with all interested parties and representatives. Wraparound Milwaukee will notify parties listed.

☐ I do not request a meeting/hearing at this time. I request a written response to my grievance.

☐ I request that the grievance be filed and do not desire any further action.

Submitted By:

Signature ___________________________ Date ___________________________

Print Name ___________________________ Phone Number (Person Filing the Complaint/Suggestion) ___________________________

Street Address, City, State, Zip Code ___________________________

Following the completion of this form, please submit to:

Mail: Wraparound Milwaukee
Attn: Pamela Erdman
9455 Watertown Plank Road
Milwaukee, WI 53226
Fax: (414)257-7575  Attn: Pamela Erdman
Email: pamela.erm@milwaukeecountywi.gov
Phone: (414)257-7608
Enrollee Name

Enrollee DOB

Person Filing the Grievance

Phone Number (Person Filing the Grievance)

Care Coordinator Name

Medicaid Type - Check One:
☐ Medicaid  ☐ Non-Medicaid

Description of Grievance (verbal dissatisfaction - specify):

Date Initiated: ______________  Was Grievant Contacted? ☐ No  ☐ Yes - If Yes, date contacted: ______________

Desired Resolution:

Was Grievant Informed of Grievance Procedure? ☐ Yes ☐ No

Grievance Date Received: __________________

I. Program Director Review

A. Nature of Grievance:
☐ Dissatisfaction with Care Coordinator’s implementation of Plan of Care (Describe):

☐ Benefit Denials (claims or benefits; refusal to refer or provide a requested service) Describe):

☐ Dissatisfaction with Service quality, provider, etc. (Date of:____)  

☐ Other (Specify):

B. Grievance Hearing Date (10 calendar days):_______________________________

1. Members Present:

  ______________________________  ______________________________

  ______________________________  ______________________________

  ______________________________  ______________________________

2. Decision (check one): ☐ Approved  ☐ Modified  ☐ Denied

3. Was additional 14 days needed? (Check one): ☐ Yes  ☐ No

Signature of Person Completing this Form

Date

Print Name

Role/Title
[Date]
[Grievant]
[Address]

Re: [Client Name]  
[Client DOB]

Dear [Grievant]:

Wraparound Milwaukee received your letter on [date] that expressed a Grievance concerning [description of grievance].

Your Grievance is important and will be evaluated by the appropriate Wraparound Milwaukee staff member. In order for us to resolve your Grievance, we will need to review all important and available information related to your Grievance. We will schedule a Grievance Hearing with you within 10 days of Wraparound Milwaukee’s receipt of your Grievance.

Before and at your Grievance Hearing, you and any representatives have the right to present evidence and allegations of fact or law in person, as well as in writing, related to your Appeal and to have access to any records (within the restrictions of the law) related to the issue being appealed.

You may contact the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 with any questions you may have regarding the Grievance process.

Sincerely,

Quality Assurance Department  
Wraparound Milwaukee

cc: Care Coordinator  
Client File
[Date]
[Grievant]
[Address]

Re:  [Client Name]
     [Client DOB]

Dear [Grievant]:

Your Grievance will be presented to Wraparound Milwaukee on [date].
The Hearing will take place at [time, date, place of Hearing].

You and your representatives have the right to be present at or before the Grievance Hearing to present additional written or verbal information that is important to your case.

You may contact the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 with any questions you may have regarding the Grievance Hearing.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
    Client File
[Date]
[Grievant]
[Address]

Re: [Client Name]
[Client DOB]

Dear [Grievant]:

Wraparound Milwaukee’s Program Level Grievance Committee met on [date] to hear your Grievance. [You were at the Hearing to present verbal or written additional information OR You were not at the Hearing to present verbal or written information].

After evaluating the available information, the decision was to [describe]. The Wraparound Milwaukee Program Level Grievance Committee Hearing is the final Grievance process available to you through Wraparound Milwaukee. You may appeal the Committee’s decision to the Administrator of the Milwaukee County Behavioral Health Division by writing to:

Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226
Attn: BHD Administrator

Or to the State of Wisconsin by writing to:

State of Wisconsin
Department of Administration
Division of Hearings & Appeals
P.O. Box 7875
Madison, WI 53707-7875

If the Behavioral Health Division can be of assistance to you in this or other matters, please feel free to call 414-257-5202.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
Client File
[Date]
[Grievant]
[Address]

Re: [Client Name]
[Client DOB]

Dear [Grievant]:

In order for the Wraparound Milwaukee Program Level Grievance Committee to resolve your Grievance, which we received on [date], we will require an additional 14 calendar days. This additional time is needed to [example: to acquire additional medical information from your primary care physician, etc.]

Following receipt of the additional information, your Grievance will be evaluated in a timely manner. It is expected that a resolution to your Grievance will be reached no later than [date - 14 calendar days from date of this letter]. You will be notified of this decision.

You may contact the Wraparound Milwaukee Quality Assurance Department at (414) 257-7608 with any questions you may have.

Sincerely,

Quality Assurance Department
Wraparound Milwaukee

cc: Care Coordinator
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