sKE

SPECIAL K ENRICHMENT, INC.

CONSUMER GRIEVANCE

Consumer Name:_____ **Record #:** _____

Medicaid #:_____ **DOB:**_____

(CHECK ONE)

_____**Initial Review** **or** _____**Request for Appeal Process**

I, _____, have the following grievance:

_____

_____

_____

_____

_____

_____

_____

_____

I will accept the following action as sufficient remedy to my grievance:

_____

_____

_____

_____

_____

_____

_____ _____

Consumer/Parent/Legal Guardian Date

_____ _____

Agency's Representative Date

Decision:

_____

_____

_____

_____

_____

_____Accepted _____Not Accepted