



John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

DEPT. OF HEALTH AND HUMAN SERVICES  
OFFICE OF ADULT MENTAL HEALTH SERVICES

Level 1 Grievance Reporting Form

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone/TTY: \_\_\_\_\_

Name of Agency/Service Provider Involved:  
\_\_\_\_\_  
\_\_\_\_\_

Location of Agency/Service Provider (city/town):  
\_\_\_\_\_

Date(s) that the incident happened: \_\_\_\_\_

Name(s) of People Involved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly Describe What Happened (use the back of this form if necessary):

What is the specific issue that needs to be addressed?

How can this matter be resolved?

## Your Notes and Contact Information



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*Caring..Responsive..Well-Managed..We are DHHS.*