ADMINISTRATIVE RESOLUTION

TO BE COMPLETED WITHIN 3 BUSINESS DAYS

104 CMR 32.04(3)

UNIT: _____ **LOG #:** _____

DATE OF COMPLAINT: ___/___/___ **DATE OF THIS REPORT**: ___/___/

RESPONSIBLE PERSON: _____

TITLE: _____

CLIENT NAME: _____
DATE OF INTERVIEW: _____

COMPLAINANT NAME (IF NOT CLIENT): _____
DATE OF INTERVIEW: _____
(NOTE, IF THERE IS MORE THAN ONE CLIENT/COMPLAINANT INVOLVED PLEASE ENTER ADDITONAL INDIVIDUALS BELOW.)

SUMMARY OF ALLEGATION: _____

_____

_____

_____

_____

_____

OTHER PERSONS INTERVIEWED:

NAME	AGENCY	POSITION	DATE
_____	_____	_____.	___/___/___.
_____	_____	_____.	___/___/___.
_____	_____	_____.	___/___/___.

DOCUMENTS REVIEWED:

_____ _____

_____ _____

_____ _____

STATEMENT OF GROUNDS FOR ADMINISTRATIVE RESOLUTION(I.E., REVIEW OF ALLEGATIONS; FACTS REQUIRING FURTHER FACT FINDING; AGREED UPON ACTIONS): _____

_____

_____

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COMPLAINT AS ALLEGED: ☐ MEETS ADMINISTRATIVELY RESOLUTION ☐ REFERRED FOR FACT FINDING

☐ RECOMMENDATIONS FOR FACT FINDING: _____

_____

_____

DATE DECISION SENT OR GIVEN TO CLIENT: ____/____/____

RESPONSIBLE PERSON SIGNATURE: _____ DATE: _____

*** Please see attached for Reconsideration/ Appeal Rights.

If you are dissatisfied with the results of this review, please be advised that you have the right to request that HOSPITAL reconsider this decision. To do so, you must put your request in writing within ten (10) days of the receipt of the attached decision and send it to:

Name of Responsible Person
Hospital Name
Hospital Address

This request must with specificity, assert 1) HOSPITAL failed to interview an essential witness or failed to consider an important fact or factor; 2) The decision is not reasonably supported by the facts; or 3) The decision is based on erroneous interpretation of applicable law or policy. The hospital will respond to your appeal within ten (10) days of your request.

You also have the right to appeal the outcome of this decision letter. All appeals must with specificity, assert, the information as outlined above and must be made in writing within ten (10) days of the receipt of the decision. Appeals should be made directly to:

Director of Licensing
Department of Mental Health
25 Staniford Street, Room M045
Boston, MA 02114
(Please include <u>your</u> current contact information)

The decision on your appeal will be given to you within thirty (30) days from the receipt of the appeal.

If you have any questions on any of these rights as explained above, please call the Human Rights Officer, (NAME OF HRO) at (HRO'S PHONE NUMBER).

Sincerely,

NAME OF RESPONSIBLE PERSON
NAME OF HOSPITAL

cc: HRO