REFERENCE NUMBER:

Is this grievance an emergency?
¿Es ésta queja una emergencia?

YES* | NO

If this is a medical or mental health emergency or you are aware of a specific and immediate threat to your life/safety, notify custody personnel immediately.

Si ésta es una emergencia médica o de salud mental, o si tiene conocimiento de una amenaza específica e inmediata contra su vida/seguridad, notifique a un alguacil de inmediato.

COUNTY OF LOS ANGELES SHERIFF'S DEPARTMENT

INMATE GRIEVANCE FORM

See the back copy for instructions.

All grievances must be filed within 15 calendar days.
Grievances will be responded to within 15 calendar days.
Appeals must be filed within 15 calendar days.

Only one grievance per form.
Solamente una queja por forma.

NAME NOMBRE	BOOKING NUMBER SU NÚMERO DE PRESO	FACILITY FACILIDAD	HOUSING LOC. LUGAR DE VIVIENDA	DATE FECHA

INMATE NAME:

I HAVE A GRIEVANCE ABOUT THE FOLLOWING:

GENERAL SERVICES	MEDICAL/MENTAL	STAFF
☐ Living conditions ☐ Classification ☐ Food ☐ Telephone ☐ Showers ☐ Visiting ☐ Property ☐ Mail ☐ Commissary/Account Balance ☐ Clothing/Linen/Bedding ☐ Educational/Vocational Programs ☐ Other (explain below)	☐ Medical Services (Place in envelope) ☐ Mental Health (Place in envelope) ☐ Dental (Place in envelope) ☐ Americans with Disabilities Act (ADA) ☐ Other (explain below)	☐ Custody Personnel ☐ Medical Staff ☐ Mental Health Staff ☐ Other (explain below) *Optional (check only if applicable):* ☐ Use of force ☐ Retaliation ☐ Harassment ☐ Racial or identity profiling Specify the type(s) in your explanation. (please refer to the reverse side of the pink copy for more information)

PLEASE EXPLAIN THE SPECIFIC ISSUE OR DATE OF INCIDENT, AND THE ACTION REQUESTED:

DATE, TIME, DAY OF OCCURRENCE	FACILITY OF OCCURRENCE	LOCATION OF OCCURRENCE

If needed, additional space is provided on the back of this page.

☐ In the event I am released prior to the disposition of this grievance, I waive my right to receive a mailed notification of the resolution.
☐ In the event I am released prior to the disposition of this grievance, I would like to receive a mailed notification of the resolution.
Mailing address _____ City _____ State _____ ZIP _____ Phone (___)_____

Attention: Conflict Resolution may be available and is voluntary for both the inmate and the involved personnel to address a grievance instead of the Department conducting a personnel investigation and determining a finding to resolve the grievance.

Inmate's Signature
X

---------- **FOR DEPARTMENT USE ONLY – DO NOT WRITE BELOW THIS LINE** ----------

Employee Receiving Grievance	Employee #	Date and Time of Collection and Review
		TIME STAMP HERE

EMERGENCY GRIEVANCES ONLY

*Watch commander notified of emergency grievance .Name Employee # Date/Time

This grievance ☐ was ☐ was not handled as an emergency. If not, please explain below.

Note: Any aspect of an emergency grievance determined to be non-emergent will be processed within the standard time frame.

If a disposition was rendered, please complete:		BRIEF SUMMARY OF ACTIONS TAKEN
FINDINGS	RELIEF	
☐ SUSTAINED	☐ GRANTED	
☐ SUSTAINED IN PART	☐ GRANTED IN PART	
☐ NOT SUSTAINED	☐ DENIED	
☐ INCONCLUSIVE	☐ RELIEF UNAVAILABLE	Full disposition shall be entered in the Custody Automated Report Tracking System (CARTS).

Inmate was notified of disposition/status/modification by: _____ (Supervisor), on _____ (Date/Time).

Supervising Nurse Receiving Grievance	Employee #	Date and Time of Review
		TIME STAMP HERE

FRONT PART 1 (WHITE COPY)

REFERENCE NUMBER:

COUNTY OF LOS ANGELES SHERIFF'S DEPARTMENT

INMATE REQUEST FORM

Only one request per form.

Solamente una solicitud por forma.

If this is a medical or mental health-related emergency or you are aware of a specific and immediate threat to your life/safety, notify custody personnel immediately.

Si ésta es una emergencia médica o tiene conocimiento de una amenaza específica e inmediata contra su vida/seguridad, notifique a un alguacil de inmediato.

NAME NOMBRE	BOOKING NUMBER SU NÚMERO DE PRESO	FACILITY FACILIDAD	HOUSING LOCATION LUGAR DE VIVIENDA	DATE FECHA

I AM REQUESTING *(only one request per form)*:

INMATE NAME:

TO SPEAK WITH	LOGISTICAL	INMATE OPPORTUNITIES	OTHER
☐ VA Representative ☐ Chaplain Religion: _____ ☐ Americans with Disabilities Act (ADA) Coordinator ☐ Other (explain below)	☐ Personal care items ☐ Legal forms ☐ Voting information ☐ Information about my mail ☐ Commissary/vending ☐ A haircut ☐ To be rehoused or reclassified ☐ Other (explain below)	☐ Educational classes ☐ Special Education - IEP ☐ Drug/alcohol treatment ☐ To be an inmate worker ☐ Fire Camp information ☐ Supervised release (i.e. ankle monitor, house arrest) ☐ Community Transition Unit (Re-entry services) ☐ Other (explain below)	☐ A credit calculation ☐ To make a positive comment about an employee ☐ Food information ☐ Other (explain below)

LEGAL INFORMATION	*(response)*	OTHER	*(response)*
☐ Next court date		☐ Account balance	
☐ Release date		☐ Telephone PIN	
☐ SP status		☐ Library time	
☐ Charge(s)		☐ Shoes/Mattress/Linen	
☐ Hold(s)/Warrant(s)		☐ A "hygiene kit"	
☐ Addresses for: Court/Parole/Probation		☐ Other:_____	

These requests may be handled by the housing officer.

PLEASE EXPLAIN THE DETAILS OF YOUR REQUEST:

---------- **FOR DEPARTMENT USE ONLY – DO NOT WRITE BELOW THIS LINE** ----------

Employee Receiving Request	Employee #	Date and Time of Collection and Review
		TIME STAMP HERE

FRONT PART 1 (GREEN COPY)

LOS ANGELES COUNTY CORRECTIONAL HEALTH SERVICES
HEALTH SERVICES REQUEST (HSR) FORM (REV. 8.2020)

HSR RECEIVED DATE/TIME	MUST STAMP

IF YOU ARE HAVING AN EMERGENCY DO NOT USE THIS FORM BUT IMMEDIATELY CONTACT THE NEAREST STAFF FOR MEDICAL ASSISTANCE

PATIENT INFORMATION					
Last Name:		First Name:		Today's Date:	
Booking Number:		Housing Location:		Date of Birth:	

PLEASE TELL US ABOUT THE HEALTH SERVICE/S YOU ARE REQUESTING

Medical Care
Check Box

☐

Dental Care
Check Box

☐

(Cleanings are scheduled after one year of incarceration)

Mental Health
Check Box

☐

Date problem started: _____

I have the following request:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

----------DO NOT WRITE BELOW THIS LINE – CHS STAFF USE ONLY----------

(**Medical** ☐ Routine ☐ Urgent) (**Dental** ☐ Routine ☐ Urgent) (**Mental Health** ☐ Routine ☐ Urgent)

Triaged by:	Emp #:	Title:	
Reviewed/Assessed by:	Emp #:	Title:	Date:

HSR TRIAGED DATE/TIME	MUST STAMP