I FAMAGU'ON-TA/CHILD ADOLESCENT SERVICES DIVISION
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE
790 GOV. CARLOS G. CAMACHO ROAD
TAMUNING, GUAM 96913

DATE: _____

REQUESTOR: _____
(NAME OF PARENT/LEGAL GUARDIAN)

I have concern(s) about: _____
(FILL IN NAME OF INDIVIDUAL OR ISSUE OF CONCERN)

I [ ] **have** or [ ] **have not** made an attempt to work this out with:

_____
(NAME OF WRAP COORDINATOR/SOCIAL WORKER)

Without success and now I want you to assist me in resolving my concerns.

☐ I would like an appointment to talk with you on _____
(FILL OUT DATE, TIME , AND LOCATION)

☐ I would like you to call me at _____
(FILL IN CONTACT NUMBER AND PREFERRED TIME)

☐ I would like you to read the information I have enclosed and contact me as soon as possible.

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN/CONSUMER

RECEIVED BY:

_____ _____
STAFF NAME/SIGNATURE DATE

OFFICE USE ONLY

DISPOSITION: _____

COMMENT(S): _____

_____
SIGNATURE OF ADMINISTRATOR/SUPERVISOR
DATE: _____

NAME: _____
DOB: _____ CHART NO. _____
TELEPHONE NO. _____

I agree with the above disposition made by the Administrator/Supervisor regarding my grievance(s). Should other issues or concerns arise, I am aware that an additional form may be filled out and submitted.

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN/CONSUMER

DATE: _____

_____
SIGNATURE OF ADMINISTRATOR/SUPERVISOR

DATE: _____

AFBU: FORM – 005 : 6/2006, 10/2010 REV. 7/2011