TO: Step III Appeal Director's Office (Grievance and Appeals Section)  P.O. Box Lansing Michigan 48909

TO: Whom this letter may concern Precisely:
MR. Richard Russell

Dear Mr. Russell on 7-19-17 I sent a Step 1-3 grievance on health care for intentional
Deliberate indifference to a serious medical need and have not received my Step 3
response back.Grievance Identification
Number is AMC-17-06-1437-12EY

These pursuit official mainly the officer who
possess our mail well throw a prisoners
step 3 I dispose it away in the trash can.
I have no way of knowing if you have sent
it or not initiative to lawsuit and
Need my step 3 response please so
I can send this to the United States
District Court to verify exhaustion
of my administrative grievance remedies
with the court. And if you have
sent it I never received my Step 3
Grievance Response on health care AMC-17-06-1437-12EY.

(Please respond) Thank You
Sincerely.** Michael D. Mayes
PRISONER: COMPLETE SECTIONS A THROUGH D

A NAME: mays

B This Health Care Request is for the following (check one or more):

☐ Health Record Copies ☐ Non-urgent
☐ Dental ☐ Medication Refill ☐ Medical ☐ Optometry ☐ Mental Health ☐ Urgent

C I have the following problems/symptoms:

D NOTICE TO PRISONER

You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoners." Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment, to review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me and I understand that I will be charged $5.00 for my health care visit unless it is for one of the reasons listed below in Section F. If I am charged for this visit, I agree that the $5.00 may be taken from my account.

Prisoner Signature: [Signature]

INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on: [Date]

Signature: [Signature]

COPAYMENT

(to be filled out by health care):

Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

☐ requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, and required follow-up care)
☐ for injuries that are work-related as documented by the prisoner's work supervisor
☐ requested for testing for HIV, STD's, infestations, or reportable communicable diseases
☐ requested for evaluation, consultation, or treatment of a mental health need
☐ prompted by a medical emergency (see Section I of the policy, if self-inflicted)

I have reviewed the visit of [Date] and certify none of these exceptions apply.

Signature: [Signature]

INCOME DISTRIBUTION:

White - Health Services
Canary - Prisoner
Pink - Business Office
NAME: \\
NUMBER: \\
LOCK: \\
DATE: \\

B. This Health Care Request is for the following (check one or more): 
- Health Record Copies 
- Dental 
- Medication Refill 
- Medical 
- Optometry 
- Mental Health 
- Urgent 

C. I have the following problems/symptoms: 
- \( \text{explain symptoms} \)

D. NOTICE TO PRISONER 
You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoner Funds."

Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment, to review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me and I understand that I will be charged $5.00 for my health care visit unless it is for one of the reasons listed below in Section E. If I am charged for this visit, I agree that the $5.00 may be taken from my account.

Prisoner Signature: \\
Date: \\

E. INSTRUCTIONS TO PRISONER 
ON THIS SAME DATE WHILE PASSING OUT 
Ms. Elizabeth told me to go to A Block. I called 
my friend was bullying and I was throwing up 
MY FOOD THEY THE STAFF KICKED YOU AND KEPT PASSING

An appointment has been scheduled for you on: \\
Date: \\

F. COPAYMENT 
(to be filled out by health care):
Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

Care that is: 
- requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, 
and required follow-up care)
- for injuries that are work-related as documented by the prisoner's work supervisor
- requested for testing for HIV, STD's, infestations, or reportable communicable diseases
- requested for evaluation, consultation, or treatment of a mental health need
- prompted by a medical emergency (see Section 1 of the policy, if self-inflicted)

I have reviewed the visit of \\
Date: \\

Distribution: White - Health Services, Canary - Prisoner, Pink - Business Office
# HEALTH CARE REQUEST

**PRISONER: COMPLETE SECTIONS A THROUGH D**

- NAME: [Redacted]
- NUMBER: [Redacted]
- LOCK: 3-214
- DATE: 5-26-17

**B. This Health Care Request is for the following (check one or more):**
- Health Record Copies
- Dental
- Medication Refill
- Medical
- Optometry
- Mental Health
- Non-urgent
- Urgent

**C. I have the following problems/symptoms:**
- [Redacted]

**D. NOTICE TO PRISONER**

You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoner Funds".

Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment, to review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me and I understand that I will be charged $5.00 for my health care visit unless it is for one of the reasons listed below in Section F. If I am charged for this visit, I agree that the $5.00 may be taken from my account.

Prisoner Signature: [Redacted]

**INSTRUCTIONS TO PRISONER**

An appointment has been scheduled for you on: [Redacted]

Signature: [Redacted]

**COPAYMENT**

(to be filled out by health care):

Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

Care that is:
- requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, and required follow-up care)
- for injuries that are work-related as documented by the prisoner's work supervisor
- requested for testing for HIV, STDs, infections, or reportable communicable diseases
- requested for evaluation, consultation, or treatment of a mental health need
- prompted by a medical emergency (see Section 1 of the policy, if self-inflicted)

I have reviewed the visit of [Redacted] and certify none of these exceptions apply.

Signature: [Redacted]

Distribution: White - Health Services, Canine - Prisoner, Pink - Business Office
**F**

**COPAYMENT**  
(to be filled out by health care):

**Note:** If none of the exceptions listed below apply, check the box below and a copayment will be charged.

- Care that is:
  - requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, and required follow-up care)
  - for injuries that are work-related as documented by the prisoner's work supervisor
  - requested for testing for HIV, STD's, infestations, or reportable communicable diseases
  - requested for evaluation, consultation, or treatment of a mental health need
  - prompted by a medical emergency (see Section 1 of the policy, if self-inflicted)

☐ I have reviewed the visit of [ ] and certify none of these exceptions apply.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Title:</th>
<th>Provider #:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Distribution:**  
White - Health Services, Canary - Prisoner, Pink - Business Office
HEALTH CARE REQUEST

A. NAME: John Doe
   NUMBER: 12345
   LOCK: 3-219
   DATE: 5-28-17

B. This Health Care Request is for the following (check one or more):
   - Health Record Copies
   - Dental
   - Medication Refill
   - Medical
   - Optometry
   - Mental Health

C. I have the following problems/symptoms:
   - Date: 5-28-17
   - Describe:

D. NOTICE TO PRISONER

You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoner Funds."

Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment. To review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me and I understand that I will be charged $5.00 for any health care visit unless it is for one of the reasons listed below in Section F. If I am charged for this visit, I agree that the $5.00 may be taken from my account.

Prisoner Signature: John Doe
   Date: 5-28-17

E. INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on:
   Signature: John Doe
   Date: 5-28-17

F. COPayment

Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

- for injuries that are work-related as documented by the prison's work supervisor
- for urgent medical treatment
- for the treatment of mental health needs
- for health care services at a medical clinic
- for treatment of injuries that are work-related and/or related to self-inflicted injuries
- for injuries that are not work-related
- for health care services provided by a health care provider

I have reviewed the visit of
   Signature: John Doe
   Date: 5-28-17

Distribution: White - Health Services, Canary - Prison, Pink - Business Office
HEALTH CARE REQUEST

PRISONER: COMPLETE SECTIONS A THROUGH D

A. NAME: 

NUMBER: 2151104

LOCK: 3-214

DATE: 5-29-17

B. This Health Care Request is for the following (check one or more):

☐ Health Record Copies
☐ Dental
☐ Medication Refill
☐ Medical
☐ Optometry
☐ Mental Health
☐ Non-urgent
☐ Urgent

C. I have the following problems/symptoms:

I.Contributory Health: Everything was done for me.

D. NOTICE TO PRISONER

You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoner Funds".

Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment, to review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me, and I understand that I will be charged $5.00 for my health care visit unless it is for one of the reasons listed below in Section F. If I am charged for this visit, I agree that the $5.00 may be taken from my account.

Prisoner Signature:

E. INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on:

Signature:

Date:

F. COPayment

(to be filled out by health care):

Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

Care that is:

☐ requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, and required follow-up care)

☐ for injuries that are work-related as documented by the prisoner’s work supervisor

☐ requested for testing for HIV, STD's, infestations, or reportable communicable diseases

☐ requested for evaluation, consultation, or treatment of a mental health need

☐ prompted by a medical emergency (see Section I of the policy, if self-inflicted)

☐ I have reviewed the visit of 

and certify none of these exceptions apply.

Distribution: White - Health Services, Canary - Prisoner, Pink - Business Office
Kite Response

Patient Name: MARCUS MAYS
Date Received: 05/24/2017
Time Received: 00:00
Taken By: Trudy A. Duquette, RN
Date Initiated: 05/24/2017

Age: 53 Years

Action & Resolution

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>User</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/24/2017</td>
<td>11:31 PM</td>
<td>Trudy A. Duquette, RN</td>
<td>Schedule Nurse Sick Call approx 05/26/2017 with RN by Trudy A. Duquette, RN. Reason: Finger swell and numb, shoulder pain, and &quot;ongoing problems&quot;. Comments: Nurse Sick Call, Lock 3-214.</td>
</tr>
</tbody>
</table>

Other

Reason: Finger swell and numb, shoulder pain, and "ongoing problems".

Comment: Nurse Sick Call, Lock 3-214.

I never refused my call out 6/26/17. I came on there and told Nurse Ustalo that I've already been x-ray on 5-26-17. I thought I was because call out about my injuries and burns there. I told the prisoner was need to keep being assessed about problem with burns. The health care is already adequate or it need to see a doctor about my head. The still refused to treat me for my injuries. OK I knew he get a doctor until he saw Stated that I would not see a doctor unless I give approval.

MAYS, MARCUS
218101
03/25/1964