AGED AND DISABLED WAIVER
Member Grievance Form

Last Name:	First Name:	Medicaid #:
Date:	Address:	Phone #:
Legal Representative Name, if applicable:	Address:	Phone #:

Statement of Complaint (Describe your concern with your services)

Relief Sought (Describe what would remedy your concern with services)

The Level One Grievance: For traditional services, the grievance must be sent to the Provider Agency. For Personal Options, the grievance must be sent to Public Partnerships (PPL). The Provider Agency or PPL will meet with you in person or by phone call to discuss the issue(s). The Provider Agency or PPL will notify you of the decision or action in response to your complaint. The Level One grievance does not come to the State first.

LEVEL ONE GRIEVANCE RESPONSE

Date of Level One Meeting with Agency Director: _______________ (in person or conference call)

Provider Agency Decision or Action Taken Date of Decision: __________________

____ ___________________________

Provider Agency Director Signature Date

- o I am satisfied with the Level One Decision
- o I am not satisfied with the Level One Decision

____ ___________________________

ADW Participant/Legal Representative Signature Date

LEVEL TWO GRIEVANCE RESPONSE

The Level Two Grievance: If you are not satisfied with the Level One response by the Agency, you may proceed to Level Two. Send to: The WV Bureau of Senior Services, 1900 Kanawha Blvd., East, Charleston, WV 25305-0160. The Director of Medicaid Operations will notify you of the decision.

Date of Meeting/Decision: _______________________ Date of Decision: ____________________________

Signature: ____________________________________ Date of Notification of Person: __________________

Decision/Action Taken

Note: Members **do not** have to file a grievance as a prerequisite for a Medicaid Fair Hearing.