

**AGED AND DISABLED WAIVER
MEMBER GRIEVANCE**

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. A Member may go to a Level Two Grievance without going through a Level One.

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LEVEL ONE GRIEVANCE RESPONSE

Date of Level One Meeting with Agency Director or PPL: _____ (In person or conference call)

Provider Agency or PPL Decision or Action Taken _____ Date of Decision _____

Provider Agency Director or PPL Signature _____ Date _____

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

Member/Legal Representative Signature _____ Date _____

LEVEL TWO GRIEVANCE RESPONSE

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

Date of Meeting/Discussion _____ Date of Decision _____

Signature _____ Date Notification of Member _____

Decision/Action Taken