

ATTACHMENT 3.D

DA/SSA GRIEVANCE OR APPEAL FORM

If you are dissatisfied with your agency, a member of its staff, or decisions about services that you receive, you may complete this form and give it to the agency's grievances & appeals coordinator so that issues can be resolved reasonably quickly. This form is made available for your convenience, but you may write your concerns down in any way you choose. Or, if you prefer, you may talk to the grievances & appeals coordinator about your concerns.

- **We encourage you to express your dissatisfaction openly.**
- **Your concerns are considered confidential.**
- **Your services will not be affected if you file a grievance or appeal an action.**
- **No staff member will treat you poorly if you express your concerns.**
- **You are entitled to an agency decision regarding your concerns and reasons for the agency's decision.**

Name: _____ (required in order to provide a response)

Address: _____ or e-mail _____

Telephone #: _____ (if preferred) Date: _____

(X) What best describes your concerns? If your concerns are about a denial, reduction, or stoppage of service, please give as much detail as possible. If your concerns are about the agency or staff, please describe the issues.

The following categories may help, but you are not limited to this list:

<u>Examples of Grievance Issues:</u>	<u>Examples of Appeal Issues:</u>
1. <input type="checkbox"/> Dissatisfaction with a staff/contractor	1. <input type="checkbox"/> Denial or limited authorization of a requested covered service.
2. <input type="checkbox"/> Dissatisfaction with management	2. <input type="checkbox"/> Reduction, suspension, or termination of an authorized service or service plan
3. <input type="checkbox"/> Dissatisfaction with program decision	3. <input type="checkbox"/> Denial, in whole or in part, of payment for a service
4. <input type="checkbox"/> Dissatisfaction with policy decision	4. <input type="checkbox"/> Failure to provide services in a timely manner
5. <input type="checkbox"/> Dissatisfaction with quality of services	5. <input type="checkbox"/> Failure to provide clinically indicated covered services
6. <input type="checkbox"/> Dissatisfaction with accessibility of services	6. <input type="checkbox"/> Denial of request for covered services outside Medicaid network
7. <input type="checkbox"/> Dissatisfaction with timeliness of response	
8. <input type="checkbox"/> Dissatisfaction with services not offered or not available	

Describe your concerns and what steps you have taken to resolve the problem so far. _____

How would you like to see the problem resolved? _____

