PERSONAL CARE
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: The grievance must be sent to the Personal Care Agency. The Personal Care Agency will meet with you in person or by phone call to discuss the issue(s). The Personal Care Agency 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: _____(In person or conference call)

Provider Agency Decision or Action Taken Date of Decision_____

_____ _____
Agency Director Signature Date

- o I am satisfied with the Level One Decision
- o 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 Personal Care Agency, 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
