PERSONAL CARE SERVICES PROGRAM
MEMBER GRIEVANCE

Last Name:	First Name:	Medicaid #:
Date:	Address:	Phone #:
Representative Name/Title (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 Provider Agency. The Provider Agency will meet with you in person or by phone call to discuss the issue(s). The Provider 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.

PERSONAL CARE SERVICES PROGRAM
MEMBER GRIEVANCE

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

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

_____ _____

PC Member/Legal Representative Signature Date

LEVEL TWO GRIEVANCE

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 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 Member Notified:_____

Decision/Action Taken
