WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

TRAUMATIC BRAIN INJURY WAIVER
PROGRAM PARTICIPANT GRIEVANCE

Last Name	First Name	Middle Initial:	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 related to your compliant. 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 APS Healthcare, Inc. first. You may submit a Level Two Grievance without going through a Level One.

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

_____ _____
Participant/Legal Representative Signature Date

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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: APS Healthcare, Inc., 100 Capitol Street, Suite 600, Charleston, WV 25301. Level Two decision will be based on Medicaid policy and/or health and safety issues. The _____ will notify you of the decision.

Date of Meeting/Discussion ___/___/_____ Date of Decision ___/___/_____

Signature _____

Date of Notification to Participant/Legal Representative ___/___/_____

Decision/Action Taken