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:

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

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

________________________________________________________________________

How would you like to see the problem resolved? _________________________________________________________________

________________________________________________________________________

Revised 12/2017
Attachment 3. E  Grievance Flow Chart

"Pertinent Issue" occurs that beneficiary wants to grieve.

Grievance Filed

Cannot exceed 90 days

Grievance Disposition

Beneficiary Orally Withdraws Grievance

Cannot exceed 10 days

Written acknowledgement of Grievance Review Request sent within 5 days

Grievance Review Requested

Written acknowledgement letter sent within 5 days

Grievance Review Disposition

Notice of Grievance Review Findings sent.

Note: All time frames are in calendar days unless otherwise specified.
Attachment 3.F

**Appeal Flow Chart**

Action occurs that beneficiary wants to appeal.

- **Cannot exceed 60 days**
  - **Expedited Appeal Filed**
    - **Meets Criteria**
      - 72 hours to decide
    - **Does Not Meet Criteria**
      - Prompt Oral Notification
      - Written notification sent within 2 days of oral communication

- **Appeal Filed**
  - Written acknowledgement letter sent within 5 days
    - If filed with wrong agency they get a transfer letter
    - If appeal for eligibility or premium issues - transfer to DVHA Health Care Appeals Team.

- **Cannot exceed 30 days**
  - Beneficiary Orally Withdraws Appeal
    - Orally Withdrawn letter sent within 5 days
    - Invitation to Meeting letter
    - Decision letter sent.

- Appeal Meeting

- Appeal Decision
  - If they do not agree with appeal decision, they have 120 days to file a fair hearing.

- **Fair Hearing**

Note: All time frames are in calendar days unless otherwise specified.

Revised 12/2017
December 20, 2017

DEAR [BENEFICIARY NAME]:

We have received your grievance about: [GRIEVANCE ISSUE]

We will look into your grievance and mail you a letter by [GRIEVANCE DUE DATE].

The Office of the Health Care Advocates may be able to help you. They can be reached at 1-800-917-7787.

If you have any questions, please feel free to call me at [INSERT PHONE NUMBER] Monday through Friday, except holidays.

Sincerely,

[Staff Name]
Grievance & Appeal Coordinator
cc: file

DVHA 220CGA-G2
12/17

Revised 12/2017
If you need interpretation services...

If you need interpretation services...

December 20, 2017

[beneficiary name]
[beneficiary address 1]
[beneficiary address 2]
[city] [state] [zip]

Dear [beneficiary name]:

We have received your request to withdraw your grievance. We will stop looking into your grievance about:

[GREevance issue]

Thank you for contacting us. If you have any further questions, please feel free to call me, at [insert phone number] Monday through Friday, except holidays.

Sincerely,

[staff name]
Grievance and Appeal Coordinator

cc: file

Grievance orally withdrawn letter

Revised 12/2017
December 20, 2017

[BENEFICIARY NAME]
[BENEFICIARY ADDRESS 1]
[BENEFICIARY ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [BENEFICIARY NAME]:

We have received your grievance about: [GRIEVANCE ISSUE]

Here is what we found: [HOW ADDRESSED]

If you are not satisfied with this response you may ask for a grievance review within the next 10 days. In a grievance review we will take another look at your grievance, how we addressed it, and the information we based our response on, and any new information that you can now give us.

If you want to ask for a grievance review or have any questions, please call me at [INSERT PHONE NUMBER] Monday through Friday, except holidays.

Sincerely,
[Staff Name]
Grievance and Appeal Coordinator

cc: file

Grievance Response Letter

Revised 12/2017
December 20, 2017

[MEMBER NAME]

[MEMBER ADDRESS 1]

[MEMBER ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [MEMBER NAME]:

We received your appeal request for:

[APPEAL ACTION]

We are not the agency to decide this appeal. We have forwarded it to [PROPER AGENCY] because they handle these appeals. You will hear from them soon. All appeals have a 30-day time frame to be decided, but may take another 14 days if more time will help you. Your appeal should be decided by [DUE DATE].

If you have any questions, please feel free to call [PROPER COORDINATOR] at [PHONE NUMBER] Monday through Friday, except holidays.

The Office of the Health Care Advocates may be able to help you with your appeal. They can be reached at 1-800-917-7787.

Sincerely,

[Staff Name]

Grievance and Appeal Coordinator

cc: File

Other Agency Coordinator

Appeal Other Agency Forward Letter

Revised 12/2017
December 20, 2017

[MEMBER NAME]

We received your appeal filed on [DATE] for:

[ACTION]

We will hold a meeting to review the decision you are appealing. We will send you another letter letting you know when this meeting will take place. You may attend this meeting in person or by phone (toll-free). You may also ask your doctor or another person to attend the meeting by phone or in person. The appeal process should not take longer than 30 days, but may take another 14 days if more time will help you.

If you have any questions about your appeal or would like to take part in the meeting, you may contact me at [INSERT PHONE NUMBER] Monday through Friday, except holidays. You may send any additional information to me. If your doctor will be sending more information, please have him or her do so as soon as possible.

The Office of the Health Care Advocates can also help you with appeals. They can be reached at 1-800-917-7787.

Sincerely,

[Staff Name]

Grievance and Appeal Coordinator

Appeal Acknowledgement Letter

Revised 12/2017
December 20, 2017

[MEMBER NAME]
[MEMBER ADDRESS 1]
[MEMBER ADDRESS 2]
[CITY] [STATE] [ZIP]

Re: Internal appeal regarding [insert service] for

Dear [MEMBER NAME]:

Your appeal request has been approved.

If you are not satisfied with our answer, you may ask for an expedited fair hearing with the Human Services Board. If you want to ask for a Fair Hearing you must do so by [FH DATE]. To ask for a fair hearing, call Green Mountain Care Member services at 1-800-250-8427 or you can contact the Human Services Board directly at 802-828-2536 or write to:

Human Services Board
14-16 Baldwin Street
2nd Floor
Montpelier, VT 05633-4302

If you request a fair hearing, you have the right to ask for continuing benefits. You need to ask for continuing benefits at the same time you request the fair hearing from Member Services or the Human Services Board. If you get services during your fair hearing, you may be asked to pay for them if the fair hearing is not decided in your favor.
The Office of the Health Care Advocates can help you with Fair Hearings. They can be reached at 1-800-917-7787.

If you have any questions, please feel free to call me at [INSERT PHONE NUMBER] Monday through Friday, except holidays.

Sincerely,

[Staff Name]
Grievance and Appeal Coordinator

cc: file

Revised 12/2017
ATTACHMENT 3.M
SAMPLE NOTICE OF ADVERSE INTERNAL REVIEW OF APPEAL

Insert Letterhead

If you need interpretation services...

December 20, 2017

[MEMBER NAME]

[MEMBER ADDRESS 1]

[MEMBER ADDRESS 2]

[CITY] [STATE] [ZIP]

Re: Internal appeal regarding [insert service]

Dear [MEMBER NAME]:

Your appeal has been denied.

This decision was made based on:

If you have any questions, please feel free to call me at [INSERT PHONE NUMBER] Monday through Friday, except holidays.

If you are not satisfied with our answer, you may ask for a Fair Hearing with the Human Services Board. If you want to ask for a Fair Hearing, you must do so by [FH DATE]. To ask for a Fair Hearing, call Green Mountain Care Member services at 1-800-250-8427 or you can call the Human Services Board directly at 802-828-2536, you may also write to:

Human Services Board
14-16 Baldwin Street
2nd Floor
Montpelier, VT 05633-4302
If you request a fair hearing, you have the right to ask for continuing benefits. You need to ask for continuing benefits at the same time you request the fair hearing from Member Services or the Human Services Board. If you get services during your fair hearing, you may be asked to pay for them if the fair hearing is not decided in your favor.

**Emergency (expedited) fair hearings may be requested in situations when you believe that the time for a regular fair hearing could seriously risk your life or health.**

The Office of the Health Care Advocates can help you with Fair Hearings. They can be reached at 1-800-917-7787.

Sincerely,

[Staff Name]
Grievance and Appeal Coordinator

cc: file

Appeal Decision Notice – Denied Letter

Revised 12/2017
ATTACHMENT 3.N
SAMPLE LETTER IN RESPONSE TO APPEAL
FILED AFTER 60 DAYS

Insert Letterhead

December 20, 2017

[RECIPIENT NAME]
[RECIPIENT ADDRESS 1]
[RECIPIENT ADDRESS 2]
[ZIP] [CITY] [STATE]

Dear [RECIPIENT NAME]:

We received your request to file an appeal on [APPEAL DATE]. Unfortunately, you did not request this appeal within the 60-day timeframe, so we are not able to process your appeal. The rules say you must appeal within 60 days of the notice that we sent to you.

The Office of the Health Care Advocates may be able to help you. They can be reached at 1-800-917-7787.

If you have any questions, please feel free to call me at [INSERT PHONE NUMBER] Monday through Friday, except holidays.

Sincerely,

[STAFF NAME]
Grievance and Appeal Coordinator
cc: file

Appeal Late Filing Letter
ATTACHMENT 3.0
SAMPLE LETTER APPROVING REQUEST FOR EXPEDITED APPEAL

If you need interpretation services...

(Arabic) 9600-899-8355

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600x2. (French)

ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600x2. (Spanish)

CHỦ Y: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-899-9600x2. (Vietnamese)

चर भविष्य: यदि आप अंग्रेजी बोलते हैं, हमें मुफ्त भाषा सहायता हेतु सेवाओं की सर्विस उपलब्ध है। कैलर करें 1-855-899-9600x2. (Hindi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos schriftliche Hilfeleistungen zur Verfügung. Rufnummer: 1-855-899-9600x2. (German)

XÓYHEEFAHNA: Afan dabatu Oromiffa, tajapila gargaar fa afan, kanfaliisaala aala, ni argama. Bilibaa 1-855-899-9600x2. (Cushitic)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-899-9600x2. (Russian)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, gratuitos. Ligue para 1-855-899-9600x2. (Portuguese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-899-9600x2 まで、お電話にてご連絡ください。(Japanese)

注意：如果您使用繁體中文，您可以在免費獲得語言援助服務。請致電 1-855-899-9600x2。 (Chinese)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistico gratuiti. Chiamare il numero 1-855-899-9600x2. (Italian)

OBAVIJESTENJE: Ako govorite srpsko-hrvatski, unutro je jezičko pomoć dostupno vašem besplatno. Nazovite 1-855-899-9600x2. (Serbo-Croatian/Bosnian)

PAUNAWA: Kang ragasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika mang walang bayad. Tumawag sa 1-855-899-9600x2. (Tagalog)

December 20, 2017

[MEMBER NAME]
[MEMBER ADDRESS 1]
[MEMBER ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [MEMBER NAME]:

We have approved your emergency (expedited) appeal request for the following:

[APPEAL ACTION]

If you are not satisfied with our answer, you may ask for an expedited fair hearing with the Human Services Board. If you want to ask for a Fair Hearing you must do so by [FH DATE]. To ask for a fair hearing, call Green Mountain Care Member services at 1-800-250-8427 or you can contact the Human Services Board directly at 802-828-2536 or write to:

Human Services Board
14-16 Baldwin Street
2nd Floor
Montpelier, VT 05633-4302

If you request a fair hearing, you have the right to ask for continuing benefits. You need to ask for continuing benefits at the same time you request the fair hearing from Member Services or the Human Services Board. If you get services during your fair hearing, you may be asked to pay for them if the fair hearing is not decided in

The Office of the Health Care Advocates can help you with Fair Hearings. They can be reached at 1-800-917-7787.

Revised 12/2017
If you have any questions, please feel free to call me at [INSERT PHONE NUMBER] Monday through Friday, except holidays.

Sincerely,

[Staff Name]
Grievance and Appeal Coordinator

cc: File

Appeal Expedited Meets Criteria – Approved Letter

Revised 12/2017
December 20, 2017

[RECIPIENT NAME]:

We received your emergency (expedited) appeal request for:

[APPEAL ACTION]

Based on the information we have, we do not agree that taking 30 days to decide your appeal could seriously risk your life, health or ability to attain, maintain, or regain maximum function.

Your appeal will now be decided in the standard 30-day time frame. Your appeal should be decided by [DUE DATE]. In some circumstances this time frame may be extended by 14 days if needed.

We have scheduled a meeting for [MEETING DATE] at [TIME] at [insert location] to discuss it. You, someone you choose to help you, and/or your doctor have the right to take part in person, by phone or in writing in the meeting. It is up to you to invite or tell those who are helping of the meeting’s date, time, and place.

You, someone you choose to help you, and/or your doctor may give us more information that adds to or explains information that was already sent. You may look at the case file, including medical records and other documents or records, before the meeting. If you ask, we can send...
you or your chosen representative copies of policies, procedures and relevant medical records, free of charge.

Please call me to let me know how you plan to attend the meeting. If you cannot attend this meeting in person, I can give you a toll-free telephone number that you can call to participate in the appeal meeting. If this date and time is not good and you would like to reschedule, please call me. If rescheduling results in us going over the 30-day limit, we will extend it by 14 days. If a meeting cannot be scheduled within the 30-day time limit plus the 14-day extension, we will have to make a decision without a meeting in order to comply with federal rules.

If you have any questions, please feel free to call me at [INSERT PHONE NUMBER] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

If you disagree with this decision you may file a grievance by calling Green Mountain Care Member services at 1-800-250-8427.

Sincerely,

[Staff Name]
Grievance and Appeal Coordinator

cc : File

Appeal Expedited – Does Not Meet Criteria Letter

Revised 12/2017
December 20, 2017

[MEMBER NAME]
[MEMBER ADDRESS 1]
[MEMBER ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [MEMBER NAME]:

We have received your verbal request to withdraw your appeal of:

[APPEAL ACTION]

Based on you withdrawing your appeal, we will no longer act on your appeal

If you have any questions, or you wish to continue your appeal, please call me, at [INSERT PHONE NUMBER].

Thank you for contacting us.

Sincerely,

[Staff Name]
Grievance and Appeal Coordinator
cc: File

Orally Withdrawn Letter

Revised 12/2017