

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

GRIEVANCE/COMPLAINT PACKET

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

INSTRUCTION: You may request assistance in completing this three page Grievance/Complaint Packet from the Health Care Integration Agency (HCIA) Representative. If you have any questions, contact the Office of Children and Family Services (OCFS) Bureau of Waiver Management (BWM) Consultation Line at 1-888-250-1832. **It is important to keep all three pages together at each step of the process.**

CHILD'S NAME (LAST, FIRST, MI.):			
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	DATE OF GRIEVANCE:

B2H WAIVER TYPE (Check one only)

- B2H Serious Emotional Disturbance (SED) Waiver
- B2H Developmental Disabilities (DD) Waiver
- B2H Medically Fragile (MedF) Waiver

SECTION A: GRIEVANCE/COMPLAINT: To be completed by the Grievant and forwarded to the HCIA Representative.

STEP 1

Type of Grievance/Complaint

- | | |
|---|---|
| <input type="checkbox"/> Service Availability | <input type="checkbox"/> Service Location |
| <input type="checkbox"/> Service Timeliness | <input type="checkbox"/> Cultural/Diversity Sensitivity |
| <input type="checkbox"/> Service Appropriateness | <input type="checkbox"/> Other (Specify) : |
| <input type="checkbox"/> Staff Action or Inaction | |

Description of Grievance/Complaint:

What would you like to see changed as a result of your Grievance/Complaint?

Attach documentation/policy/procedure to support your Grievance/Complaint, if applicable.

GRIEVANT NAME:	PHONE #:	RELATIONSHIP TO CHILD:	
GRIEVANT ADDRESS:	CITY:	STATE:	ZIP CODE:
GRIEVANT SIGNATURE: X		DATE:	

STEP 1

SECTION B: HCIA RESPONSE TO GREIVANCE/COMPLAINT: To be completed by HCIA Representative and returned to Grievant within 5 days of receipt of **Step 1, Section A Grievance/Complaint** (above). HCIA Representative must complete the name and address of OCFS Regional Quality Management Specialist (QMS) on page 2.

* Description of HCIA Response:

Attach documentation/policy/procedure to support your response, if applicable.

HCIA REPRESENTATIVE NAME:	HCIA REPRESENTATIVE SIGNATURE: X	DATE:	
HCIA REPRESENTATIVE ADDRESS:	CITY:	STATE:	ZIPCODE:

***If Grievant is not satisfied with the Step 1, Section B HCIA, Response, Complete Step 2, Section A.**

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CHILD'S NAME (LAST, FIRST, MI.):

DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	DATE OF GRIEVANCE:
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STEP 2	SECTION A: APPEAL OF HCIA RESPONSE: To be completed by the Grievant no later than 5 days after the date the HCIA, Step 1 Section B Response is received. Mail the completed Grievance/Complaint Packet, with supporting documentation, to the OCFS Regional Quality Management Specialist (QMS).	DATE STEP 1, SECTION B, RESPONSE RECEIVED: / /
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OCFS QMS NAME:	PHONE #:
OCFS QMS ADDRESS:	CITY: STATE: ZIP CODE:

What is it about the HCIA Representative's **Step 1 Response** that fails to address your Grievance/Complaint? *(please explain)*

Attach documentation/policy/procedure to support your Grievance/Complaint, if applicable.

GRIEVANT NAME:	GRIEVANT SIGNATURE: X	DATE:
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STEP 2	SECTION B: OCFS REGIONAL QUALITY MANAGEMENT SPECIALIST (QMS) DECISION: To be completed and returned by the OCFS QMS to the Grievant within 7 days of Step 2, Section A Appeal of the HCIA Response receipt date.	DATE STEP 2, SECTION A, APPEAL OF RESPONSE RECEIVED: / /
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*Description of QMS Decision *(Check One)*:

Resolution-describe below Grievance/Complaint appeal denied-describe below

Attach documentation/policy/procedure to support your response if applicable.

OCFS QMS STAFF NAME:	OCFS QMS STAFF SIGNATURE: X	DATE:
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***If Grievant is not satisfied with the Step 2, Section B QMS Decision, Complete Step 3, Section A.**

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CHILD'S NAME (LAST, FIRST, MI.):

DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	DATE OF GREIVANCE:
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STEP 3	SECTION A: APPEAL OF OCFS REGIONAL QUALITY MANAGEMENT SPECIALIST (QMS) DECISION: To be completed within 7 days of Step 2, Section B Regional QMS Decision and returned by the Grievant to OCFS Bureau of Waiver Management (BWM) at: OCFS Bureau of Waiver Management (BWM)	DATE STEP 2, SECTION B, DECISION RECEIVED: / /
	Describe your reason for the appeal. <i>(please explain)</i>	

Attach documentation/policy/procedure to support decision if applicable.

GRIEVANT NAME:	GRIEVANT SIGNATURE: X	DATE:
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NOTE: The Step 3 Decision of the OCFS Representative is the Final Step in the OCFS Grievance/Complaint Process.

STEP 3	SECTION B: OCFS BUREAU OF WAIVER MANAGEMENT (BWM) FINAL DECISION: To be completed by the OCFS BWM staff. At this step of the Grievance/Complaint process, OCFS may contact the Child, Medical Consenter, Grievant and anyone the Child or Medical Consenter chooses regarding the status of their Step 2 Appeal.	DATE STEP 3, SECTION A, APPEAL OF DECISION RECEIVED: / /
	Check One: <input type="checkbox"/> Resolution-describe below <input type="checkbox"/> Grievance/Complaint appeal denied-describe below	

Attach documentation/policy/procedure to support the decision if applicable.

OCFS BWM STAFF NAME:	OCFS BWM STAFF SIGNATURE: X	DATE:
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