**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:**  
- [ ] Male  
- [ ] 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.

<table>
<thead>
<tr>
<th>Type of Grievance/Complaint</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Availability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Timeliness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Appropriateness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Action or Inaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:**

**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.

**STEP 1**

*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:**  
**ZIP CODE:**

*If Grievant is not satisfied with the Step 1, Section B HCIA, Response, Complete Step 2, Section A.*
# BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

**GRIEVANCE/COMPLAINT PACKET**

**NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES**

---

**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).

<table>
<thead>
<tr>
<th>OCFS QMS NAME:</th>
<th>PHONE #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCFS QMS ADDRESS:</td>
<td>CITY:</td>
</tr>
<tr>
<td>STATE:</td>
<td>ZIP CODE:</td>
</tr>
</tbody>
</table>

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:**

**DATE:**

---

**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.

*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:**

**DATE:**

---

*If Grievant is not satisfied with the Step 2, Section B QMS Decision, Complete Step 3, Section A.*
<table>
<thead>
<tr>
<th>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)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe your reason for the appeal. (please explain)</td>
</tr>
<tr>
<td>Attach documentation/policy/procedure to support decision if applicable.</td>
</tr>
<tr>
<td>GRIEVANT NAME:</td>
</tr>
<tr>
<td>OCFS BWM STAFF NAME:</td>
</tr>
</tbody>
</table>

**NOTE:** The Step 3 Decision of the OCFS Representative is the Final Step in the OCFS Grievance/Complaint Process.