



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Andy Beshear
Governor

275 East Main Street, 6W-B
Frankfort, KY 40621
www.chfs.ky.gov

Eric C. Friedlander
Acting Secretary

Pam Smith
Division Director

Stephanie M. Bates
Acting Commissioner

To: All 1915(c) Home and Community Based Services Waiver Participants

From: Pam Smith
Director, Division of Community Alternatives

Date: December 20, 2019

Re: Reconsiderations, Appeals and Grievances

The Department for Medicaid Services (DMS) recently changed the way services on your person-centered service plan are approved. DMS wants to make sure you know if you disagree with your plan or a decision made by DMS, you have a right to let us know.

1. If you disagree with an adverse action by DMS decision, you can ask for a reconsideration. An adverse action is a decision about your care, such as a denial of level of care.
2. If you disagree with an adverse action by DMS, you can also file an appeal. Participants can choose to file a reconsideration, an appeal or both.
3. If you are unhappy with DMS, a provider, or your plan, you can submit a grievance. You do not have to receive an adverse action to file a grievance.

DMS has attached more information about the reconsideration, appeal, and grievance processes to this letter including information on how to file each one.

If you have additional questions, please contact the 1915(c) Waiver Help Desk by calling (844) 784-5614 or emailing 1915cwaiverhelpdesk@ky.gov.

Sincerely,

Pam Smith
Director, Division of Community Alternatives

What Does This Mean to Me? Reconsiderations, Appeals and Grievances

December 2019

The Commonwealth of Kentucky allows participants to voice disagreements and complaints with the Department for Medicaid Services (DMS) about their 1915(c) Home and Community Based Services (HCBS) waiver services. DMS has methods in place to support how you voice your disagreement or complaint, as well as how we must respond. When you share your disagreement or complaint, keep in mind:

- DMS must consider all sides and available facts.
- DMS cannot dis-enroll you from the waiver for requesting an appeal or submitting a grievance.
- DMS cannot treat you differently because you let us know you did not like something.

There are three ways to voice your waiver disagreements or concerns: reconsiderations, appeals or grievances.

Reconsideration

- You can ask for a **reconsideration** when you receive an **adverse action** from DMS. An **adverse action** is a decision about your care such as a denial of level of care or the services you can receive. You will receive an **adverse action notice** when this type of decision is made.
- To request a **reconsideration**, you must make your request in writing within 14 days of the date on your **adverse action** notice. You can email your request to 1915cwaiverhelpdesk@ky.gov or mail it to:

Department for Medicaid Services
Division of Community Alternatives
275 East Main Street, 6W-B
Frankfort, Kentucky 40621
- DMS will review the request. Staff **who were not involved** in the original determination will complete the **reconsideration** review.

Appeal

- You can file an **appeal**, in addition to a **reconsideration**, when you disagree with an **adverse action** by DMS.
- To file an appeal, you must write a letter requesting an **administrative hearing** and send it to DMS within 30 calendar days of the date on your **adverse action** notice.
- Only a participant, or his or her authorized representative, such as a guardian or legally designated power of attorney may make this request. Appeals should be sent to:

Office of the Ombudsman and Administrative Review
Medicaid Appeals and Reconsiderations
275 East Main Street 2E-O
Frankfort, Kentucky 40621
- An **administrative hearing** will be held to determine if the **adverse action** should stay the same or be changed.

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- If you wish to continue receiving services, your request for an **administrative hearing** must be postmarked or received within ten calendar days of the date on the **adverse action notice**.
- You have the right to review the case record relating to the issue and submit additional information in support of your claim.
- At the hearing, waiver participants, applicants, authorized representatives or guardians may be represented by legal counsel, a relative, a friend, or other spokesperson or you may represent yourself.

Grievance

- You can file a **grievance** when you are unhappy with DMS, a provider or your waiver services. **You do not need to have received an adverse action in order to file a grievance.**
- **Grievances** may include but are not limited to, the quality of care or services you receive, a problem with a provider or an employee, or a violation of your rights as a waiver participant, or a dispute about the time it takes DMS to make service decisions.
- To file a **grievance**, you can fill out the attached form and email it to 1915cwaiverhelpdesk@ky.gov or mail it to:

Department for Medicaid Services
Division of Community Alternatives
275 East Main Street, 6W-B
Frankfort, Kentucky 40621

If you need assistance filing a grievance or appeal, you may contact the Office of the Ombudsman and Administrative Review at (800) 372-2973 **OR** the Department of Community Based Services located in your county regarding the availability of free representation by legal aid services.

Kentucky Department for Medicaid Services

1915(c) Waiver Grievance Form



Once completed, please email form to 1915cwaiverhelpdesk@ky.gov or mail it to:
Department for Medicaid Services
Division of Community Alternatives
275 E. Main St., 6W-B
Frankfort, Kentucky 40621

Date

Name of Person Filing Grievance

Email Address

Phone Number

Check One:

- I am a waiver participant.
- I am filing a grievance on behalf of a waiver participant.*

***If filing on behalf of a waiver participant, please state your relationship to the individual:**

Waiver Participant Information

Participant's Name

Participant's Address

Participant's Date of Birth

Participant's MAID Number

Please Explain Your Grievance

Click or tap here to enter text.

Please Explain Your Desired Outcome

Click or tap here to enter text.

Signature of Person Filing Grievance

Date

Information below to be completed by DMS staff.

Received By (Please Print Name)

Date