1915(c) Home and Community Based Services Waiver Programs
Waiver Participant Grievance and Complaint Form

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

This form is intended for use by 1915(c) Home and Community Based Services **waiver participants or individuals acting on a waiver participant's behalf** to address disagreements with the Cabinet for Health and Family Services, a provider, or their waiver services. Direct support professionals or Participant Directed Services employees should address grievances and complaints with their employer.

Date

Name of Person Filing Grievance or Complaint

Email Address

Phone Number

Check One:

☐ **I am a waiver participant.**

☐ **I am submitting this form 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 or complaint.

Please describe any steps you have already taken to resolve this issue.

Please explain your desired outcome.

Signature of Person Submitting Form **Date**

Once you have completed the form, please submit it to the agency listed under the waiver you use. If your complaint or grievance is related to Participant Directed Services, please submit it to the Department for Aging and Independent Living.

Acquired Brain Injury Acute Waiver **Acquired Brain Injury Long Term Care Waiver** **Modell Waiver** Department for Medicaid Services 1915cwaiverhelpdesk@ky.gov (844) 784-5614	**Home and Community Based Waiver** **Participant Directed Services in any waivers** Department for Aging and Independent Living HCBInquiries@ky.gov (877) 315-0589	**Michelle P. Waiver** **Supports for Community Living Waiver** Department for Behavioral Health, Developmental and Intellectual Disabilities DDID.Info@ky.gov (502) 564-7700

Staff with the appropriate agency will review the form, classify it as a complaint or grievance, and issue a response or work with you on a resolution. If you have questions about your complaint or grievance, please contact the agency to which you submitted the form.

The following information to be completed by CHFS staff.

Received by (Please Print Name)	**Date**

After review, this submission is classified as a:

☐ grievance

☐ complaint

Response from CHFS

If you have additional questions, please contact the agency check marked agency below (*CHFS staff, please check the appropriate agency*):

☐ Department for Medicaid Services
1915cwaiverhelpdesk@ky.gov
(844) 784-5614

☐ Department for Aging and Independent Living
HCBInquiries@ky.gov
(877) 315-0589

☐ Department for Behavioral Health, Developmental and Intellectual Disabilities
DDID.Info@ky.gov
(502) 564-7700