Lamoille County Mental Health Services
GRIEVANCE AND 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:

Examples of Grievance Issues:

1. ☐ Dissatisfaction with a staff/contractor
2. ☐ Dissatisfaction with management
3. ☐ Dissatisfaction with program decision
4. ☐ Dissatisfaction with policy decision
5. ☐ Dissatisfaction with quality of services
6. ☐ Dissatisfaction with accessibility of services
7. ☐ Dissatisfaction with timeliness of response
8. ☐ Dissatisfaction with services not offered or not available

Examples of Appeal Issues:

1. ☐ Denial or limited authorization of a requested covered service.
2. ☐ Reduction, suspension, or termination of an authorized service or service plan
3. ☐ Denial, in whole or in part, of payment for a service
4. ☐ Failure to provide services in a timely manner
5. ☐ Failure to provide clinically indicated covered services
6. ☐ Denial of request for covered services outside Medicaid network

Describe your concerns and what steps you have taken to resolve the problem so far: _____

_____

_____

How would you like to see the problem resolved? _____

_____

_____