TEMPLATE G(1)

NOTICE FOR FAILURE OF CHC-MCO TO MEET COMPLAINT OR GRIEVANCE TIME FRAMES

[Date Notice Mailed (1 day after the date the decision was to be made)]
Participant Name
Address
City, State Zip
Participant ID: *********

Subject: Your **[Complaint] [Grievance]** About **[Issue]**

Dear **[Participant Name]**:

[CHC-MCO Name] has not told you its decision on your **[Complaint] [Grievance]** about **[identify subject of Complaint/Grievance]**, filed on **[date]**, within **[number that is 30 or fewer days]**, as required. We expect to be able to tell you our decision about your **[Complaint] [Grievance]** by **[date]**.

If you are unhappy that **[CHC-MCO Name]** has not told you about its decision on your **[Complaint] [Grievance]** within **[#]** days of getting it, you may file a Complaint with **[CHC-MCO]** or ask for a Fair Hearing from the Department of Human Services.

File a Complaint

If you want to file a Complaint with **[CHC-MCO Name]** about the delay in deciding your **[Complaint] [Grievance]**, you must file the Complaint **within 60 days from the date you get this notice.**

[CHC-MCO Name] will tell you its decision about this new Complaint within **[30, unless the CHC-MCO will be using a shorter time frame to provide notice of 1st level Complaint decisions]** days from when **[CHC-MCO Name**] gets your Complaint.

To file a Complaint:

By Phone: Call **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #];**

By Fax: Fax the "Complaint Request Form" or a letter to **[CHC-MCO FAX #];**

By Mail: Mail the "Complaint Request Form" or a letter to the following address:

**[CHC-MCO ADDRESS
FOR FILING COMPLAINT]**

Ask for a Fair Hearing

If you want to ask for a Fair Hearing from the Department of Human Services about the delay in deciding your **[Complaint] [Grievance],** your request for a Fair Hearing must be in writing and must be postmarked **within 120 days from the date on this notice.** You can either fill out and sign the "Fair Hearing Request Form" or write a letter.

If you write a letter, it needs to include the following information:

- Your (the Participant's) name, Participant ID and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone; and
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Send your request for a Fair Hearing to the following address:

Department of Human Services
OLTL/Forum Place 6th FL
CHC Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, PA 17105-8025

The Department will make a decision within 90 days from when you filed your **[Complaint] [Grievance]** with **[CHC-MCO Name]**, not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

Help with Your Complaint or Fair Hearing

If you need help filing a Complaint or asking for a Fair Hearing, you can call **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**.

To ask for free legal help with filing a Complaint or asking for a Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[CHC-MCO Name]

cc: **[Participant Representative, if designated]**

COMPLAINT REQUEST FORM

Participant: _____ **Participant ID #:** _____

Phone number: _____

Address: _____

Date on the Denial Notice: _____

1. **Check how you would like to be present at the review of your Complaint:**

   ☐ **BY TELEPHONE** (You will be sent the date and time of the review at least 10 days before the Complaint review. You will be called at the phone number you provided above.)
   ☐ **BY VIDEOCONFERENCE [CHC-MCO to include only if available]** (You will be sent the date and time of the review at least 10 days before the Complaint review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review at least 10 days before the Complaint review.)
   ☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the Complaint review. The decision on your Complaint or Grievance will not be affected if you are not present.)

2. **Do you need an interpreter? Yes ☐ No ☐ Language?** _____
   The interpreter will be free.

3. **If someone will be helping you with your Complaint, please provide his or her information:** (If you do not yet have anyone helping you, just leave this blank and you can let **[CHC-MCO Name]** know later if someone will be helping you.)

   Representative's name and phone number:

   _____

   Representative's address: _____

   Relation to Participant: _____

Participant's Signature: _____ **Date:** _____

Mail to: **[CHC-MCO Complaint address]**
Fax to: **[CHC-MCO fax #]**

FAIR HEARING REQUEST FORM

(Please include a copy of the notice from the **[CHC-MCO Name]** with this form)

Participant: _____ **Participant ID #:** _____

Phone number: _____

Address: _____

1. **Check how you would like to be present at the Fair Hearing:**

   ☐ **BY TELEPHONE** (You will be sent the date and time of the Fair Hearing. You will be called at the phone number you provided above.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the Fair Hearing.)

2. **Do you need an interpreter? Yes ☐ No ☐ Language?** _____
   The interpreter will be free.

3. **If someone will be helping you with your Fair Hearing, please provide his or her information:** (If you do not yet have anyone helping you, just leave this blank and you can let the Department of Human Services know later if someone is helping you.)

   Representative's name and phone number:_____

   Representative's address: _____

   Relation to Participant: _____

Participant's Signature: _____ **Date:** _____

Send to: Department of Human Services
OLTL/Forum Place 6th FL
CHC Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, PA 17105-8025

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]