Required Language on Grievance and Appeals for Member Guides for ACEs and CCEs
Illinois Department of Healthcare and Family Services

GRIEVANCES AND APPEALS

If You Have a Problem or Complaint

[ACE Name] (ACE Abbreviation) wants you to get the best possible service. When something goes wrong or you are not treated well, we want to know.

I. GRIEVANCES

A grievance is a complaint to [ACE Name] about any matter involving [ACE Abbreviation] other than a denied, reduced or terminated service or medical item.

[ACE Name] takes member grievances very seriously. We want to know what is wrong so we can make our services better. [ACE Name] has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your problem or concern. Filing a grievance will not affect your health care services or your benefits coverage.

These are examples of when you might want to file a grievance with [ACE Abbreviation]:

- Your medical provider or a [ACE Name] staff member did not respect your rights.
- You had trouble getting an appointment with your provider or Care Coordinator, or talking with your provider or Care Coordinator, in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a [ACE Name] staff member was rude to you.
- Your provider or a [ACE Name] staff member was insensitive to your cultural needs or other special needs you may have.

Step 1: How to file a grievance.
If you have a grievance about your Primary Care Provider, [ACE Name], or the service you have received:

1. You can call the [ACE Name] Helpline at 1-XXX-XXX-XXXX **- Toll Free; or 1-XXX-XXX-XXXX - Voice/TTY** to report it.
2. You can put your grievance in writing and mail, email or fax it to:
   [ACE Name]
   [ACE Street Address]
   [City], Illinois XXXXX
   Fax Number 1-XXX-XXX-XXXX
   Email (optional for ACE)
3. You can also register your grievance on the [ACE Abbreviation] website, [www.xxxxxxxxxxxxxxxxxxxx.xxx].

When you file your grievance, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved, and details about what happened. Be sure to include your name and your [ACE Name] member ID number.

You can designate another person to help you file a grievance with us. You will need to fill out the Authorized Representative Designation form. This form is on the [ACE abbreviation] website, [www.xxxxxx]. You can also obtain this form by calling [ACE Name] Helpline at 1-XXX-XXX-XXXX.

Step 2: Reviewing your grievance

We will make a record of your grievance. We will have someone not involved with the matter you are complaining about review your grievance and try to find a solution. Your satisfaction is important to us.

Step 3: Taking action on your grievance

We take action on all grievances within 30 days of receiving it. We will let you know what we decide.

Step 4: If you are not satisfied with the action we take on your grievance, you may write to:

Illinois Department of Healthcare and Family Services
Bureau of Managed Care
Attn: ACE Grievances
401 South Clinton Street, 6th Floor
Chicago, IL 60607

Someone from HFS will review the matter and follow up with you as quickly as possible.

II. APPEALS

You may not agree with a decision or an action made by the Illinois Department of Healthcare and Family Services (HFS) or the Illinois Department of Human Services (DHS). An appeal is a way for you to ask for a review of the Department's (HFS or DHS) actions and decisions. For example, you may not agree with a decision made or an action by the Department about your services or a medical item you requested.

You may appeal within **sixty (60) calendar days** of the date on the letter from the Department informing you of its denial or action. If you want your services to stay the same while you appeal, you must file your appeal no later than **ten (10) calendar days** from the date on the Department's letter informing you of its denial or action. You can designate another person to help you file an appeal with us. We will need something in writing that authorizes that person to speak on your behalf. When you appeal, you are asking for a hearing to review the Department's action or decision that you disagree with. The person reviewing the Department's action or decision will be a hearing officer.

The list below includes examples of when you might want to file an appeal. You may want to appeal if the Department:

- Does not approve or pay for a service or item that you or your provider asks for
- Stops your benefits (coverage)
- Says that you will start to get fewer benefits
- Changes your co-payments

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You can also appeal if you think the Department made a mistake about any action or decision. You may not get a hearing on your appeal if the Department's action or decision was because of a change in the law.

How to Make an Appeal
When you file your appeal, tell the Department what action or decision you disagree with and want them to review. Be sure to include your name, address, phone number, email, and your HFS Medical Card Identification Number (the "ID#" next to your name on the Medical Card).

An appeal is filed either with HFS or DHS, depending on the agency that made the decision you are contesting. Generally, appeal is filed with the agency that made the decision and sent you the letter informing you of its denial or action.

- If you want to file an appeal related to your medical services or items, Developmental Disability(DD), or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing via mail, fax, or email to:

  Illinois Department of Healthcare and Family Services
  Attn: Fair Hearings Section
  401 South Clinton, 6th Floor
  Chicago, IL 60607
  Fax #: 1-312-793-2005
  Email: HFS.FairHearings@illinois.gov

  Or you may call **HFS** at 1-855-418-4421. If you use a TTY, call HFS at 1-877-734-7429. The call is free.

- If you want to file an appeal related to your Medicaid application eligibility, food stamps, TANF, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Service Program (HSP) services, send your request in writing via mail, fax, or email to:

  Illinois Department of Human Services
  Attn: Bureau of Hearings
  401 South Clinton, 6th Floor
  Chicago, IL 60607
  Fax #: 1-312-793-3387
  Email: DHS.BAHNewAppeal@illinois.gov

  Or you may call **DHS** at 1-800-435-0774. If you use a TTY, call DHS at 1-877-734-7429. The call is free.