Participant Grievance/Appeal Procedure

All of us at LIFE share the responsibility for assuring that you are satisfied with the care you receive. We **ENCOURAGE** you to express any complaints you have at the time and place any dissatisfaction occurs. To be consistent with federal regulations for the program, your complaints or dissatisfaction with our program or decisions are identified as either grievances or appeals. Those processes are described below.

Grievance Procedure

The definition of a grievance is a complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished.

• Discuss your grievance with any staff member. Give complete information so that appropriate staff can help to resolve your concern in a timely manner.

• The staff that receives your grievance will discuss with you and provide in writing the specific steps including time-frames for response that will be taken to resolve your grievance. The grievance will be reported to the health team within 5 working days.

• If a solution is found by the staff and agreed to by you and/or your family/caregiver within 5 working days of making the grievance, the grievance is resolved.

• If you are not satisfied with the solution, the staff will send a written report to the Executive Director (clinical complaints will be reviewed by qualified clinical personnel) for review, to be completed within 5 working days.

• Immediately after review (but within 5 working days), a copy of a written report will be sent to you and/or your family/caregiver.

• If you are still dissatisfied with the results, you may submit a request in writing within 30 days to ask for a review by LIFE's Plan Advisory Committee.

• The Plan Advisory Committee will send written acknowledgment of receipt of the grievance within 5 working days to you, investigate, find a solution and take appropriate actions.

• The committee will send you a copy of a report containing a description of the grievance, the actions taken to resolve the grievance and the basis for such action. The committee has 30 working days from the day the grievance is filed with the committee to complete its report and send it to you.

• If the decision is not in your favor, a copy of the report will be forwarded immediately to the federal government, the Pennsylvania Department of Human Services and the local Area Agency on Aging.

Appeal Procedure

The definition of an appeal is action taken by you with respect to your disagreement with our non-coverage of or non-payment for a service, denial of enrollment, or your involuntary disenrollment from the program.

You will be notified in writing if we:

• will not cover or pay for a service that you are receiving or requesting;

• are denying enrollment into LIFE; or

• are initiating an involuntary disenrollment from LIFE.

The notice will instruct you how to appeal our decision if you do not agree with it. You must request an appeal within 30 days of our notice to you. *An involuntary disenrollment for non-compliance with your care plan or conditions of participation, engaging in disruptive or threatening behavior, failing to pay or make satisfactory arrangements to pay, or being out of the service area for more than 30 days without prior approved arrangements, will automatically be considered an appeal.*

• Confirmation of receipt of your request for appeal will be sent to you within 24 hours of receipt of your request.
• We will continue to furnish disputed services until a final determination is made **if you appeal within 30 days of our notice to you; if we are proposing to terminate or reduce services you are currently receiving; and if you agree that you will be liable for the costs of the disputed services if the appeal is not resolved in your favor**.
• An impartial party will review your appeal and you will be notified in writing of the date and time of that review to have an opportunity to present evidence related to your dispute.
• You will receive a written report of the third party review within 30 days of receipt of your appeal. That report will describe the appeal, actions taken, and outcome of the review.
• If your appeal is resolved in your favor, we will provide or pay for the disputed service right away.
• If the decision is not in your favor, a copy of the written report from the third party review will be forwarded immediately to the federal government, the Pennsylvania Department of Human Services and the Local Area Agency on Aging. You will also be notified in writing of your additional appeal rights under Medicare, or Medical Assistance through the State Fair Hearing Process. We will assist you in choosing which to pursue and forward the appeal to the appropriate entity.
• If you believe that your life, health, or ability to regain function would be seriously jeopardized if you do not receive the service in question, you can request in writing that we speed up the appeal process. In that case you will receive the outcome of the appeal within 72 hours of receipt of your appeal.