BRHPC (Premium Assistance) Internal Client Complaint/Grievance Procedure

BRHPC has an established Internal Client Complaint/Grievance Procedure which includes a statement regarding a client's right to file a complaint/grievance regarding the quality and manner services were provided. BRHPC will respond to a client Complaint/Grievance verbally within two (2) days and written within ten (10) business days. The maximum time from client filing a complaint/grievance to final resolution should not exceed thirty (30) calendar days.

Complaint/Grievance Procedures, as well as a *Statement of Clients Rights and Responsibilities,* must be available to clients in English, Spanish, and Creole.

Staff must post a notice of the organization's Internal Client Complaint/Grievance Policy in general service areas and waiting areas; on Patient Information Boards; and near elevators, entrances and/or exits.

The Complaint/Grievance procedures and forms will be provided directly to the client as requested. Complaints/Grievances should be directed accordingly to:

Insurance Complaints/Grievances: Attention: Insurance Agent, Matt Anthony
Payment Complaints/Grievances: Attention: Payment Manager, Cristy Kozla

Premium Assistance Complaint/Grievance Process

It is BRHPC's policy to consistently respond with diligence to concerns and complaints/grievances voiced by clients, case managers and other interested parties about the administration of the program or policy issues regarding the program.

Client Complaint/Grievance Process

Any client of Broward Regional Health Planning Council, Inc. may file a Complaint/Grievance if he/she has a concern regarding any issue involving the Premium Assistance Program or any associated services provided by or through Broward Regional Health Planning Council. Client voicing the concern should clearly explain their complaint/grievance and communicate what they feel needs to occur for the complaint/grievance to be resolved. The complaint/grievance and agreed resolution will be kept by the program in a secure cabinet. In those instances when the Insurance Agent and/or Payment Manager cannot resolve a client complaint/grievance or concern, the client will complete a *Written Complaint/Grievance Form* to be evaluated directly by the Vice President of Programs. The staff member involved will take all reasonable steps to bring a satisfactory resolution of the concern or complaint/grievance without undue delay.

In order to initiate a Complaint/Grievance, the client must complete the *Written Complaint/Grievance Form*. Unless there is good cause for delay, a completed Complaint/Grievance Form must be received by the program, within thirty (30) days of the date of the issue being grieved. If filed after that time, the Complaint/Grievance Form must be accompanied by a written explanation for the delay. Insurance Agent, Matt Anthony, or Payment Manager, Cristy Kozla, will decide whether the client had good cause for filing the Complaint/Grievance late. Good cause consists of hospitalization, serious illness, or other circumstances beyond the client's control, which significantly impaired their ability to file the Complaint/Grievance in a timely manner.

Insurance Agent Matt Anthony or Payment Manager Cristy Kozla will make a final decision on the Complaint/Grievance based on review of pertinent information necessary to determine if the Complaint/Grievance has validity and identify a resolution. Written notification of the Complaint/Grievance

finding will be sent to the client via certified mail, return receipt requested within ten (10) business days of the determination.

If the client is not satisfied with the solution provided by the Insurance Agent or Payment Manager, the client may appeal this decision to the Vice President of Programs. This must be done in writing and may be sent by mail or by fax. The Vice President of Programs will communicate a response to the client in writing within ten (10) business days of receipt of the Written Appeal.

Premium Assistance Compaint/Grievance Decision Appeal Process

Premium Assistance appeals must be in writing and must be directed to the Vice President of Programs. The Premium Assistance Decisions Appeals Process applies to any decision by the Premium Assistance program, which may adversely affect the client's eligibility for services. Appeals may be filed for denial of Premium Assistance services.

Appeals Procedure. In order to initiate an Appeal, the client must complete the *Premium Assistance Appeal Form*, that will be provided directly to the client as requested. Unless there is a good cause for delay, a completed *Premium Assistance Appeal Form* must be postmarked, or received by the program, within thirty (30) days of the date of the decision being appealed. If filed after that time, the appeal must be accompanied by a written explanation for the delay. The Vice President of Programs will decide whether the client had good cause for filing the appeal late. Good cause consists of hospitalization, serious illness, or other circumstances beyond the client's control, which significantly impaired their ability to file the appeal in a timely manner.

Determination of Merit. Appeals will be reviewed and considered by the Vice President of Programs and written on the Appeal Form provided by the client. The Vice President of Programs will determine the merit of the appeal based on review of what type of new or additional information is provided by the client. In order for an appeal to be approved, the client must provide new or additional information that addresses or overcomes the reason(s) for the client's Premium Assistance services being denied. The client's appeal will, also, be considered in conjunction with the Premium Assistance policies and procedures, HRSA rules and guidelines and other applicable regulations.

Approved Appeals. If the information provided by the client with the appeal application is enough to overcome the reasons(s) for the client's original denial, the client's appeal will be approved, and services reinstated. If the information provided is not enough, the required information should be provided by the client within five (5) business days of being requested. If the information is provided during the allotted period and the supporting documentation overcomes the reason(s) for the client's denial of services, the client's appeal will be approved, and services reinstated. Written notification of the client's appeal approval will be sent to the client, via certified mail within ten (10) business days of the determination.

Disapproved Appeals. If the information is not provided within the allotted period or if the client did not provide any new or additional information and supporting documentation along with the Appeal Form, the client's appeal will be deemed not eligible for services and their appeal will be disapproved. Upon completion of the client's appeal process, a written notification of the client's appeal disapproval will be sent to the client, via certified mail within ten (10) business days of the determination. Appeal decisions are considered FINAL.

Premium Assistance Insurance Complaint/Grievance Form

Client Name: ___________________________________ **Phone:** ________________________

Client Address: ____

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Complaint/Grievance Detail:
(*Provide a concise statement of facts related to the complaint/grievance, including dates and persons involved-attach a continuation page, if necessary*)

Remedy Sought by the Complainant/Grievance:
(*Be specific as to what resolution you are seeking*)

Send completed form to: Broward Regional Health Planning Council, Inc. 200 Oakwood Lane, Suite 100 Hollywood, FL 333020 – or- By Fax: (833) 297-2290 Attention: Matt Anthony

……………………………………………………………………………………………….
For Office Use Only:

Date Complaint/Grievance Form Received: ____________________

Received By: ________________________

Premium Assistance Paymente Complaint/Grievance Form

Client Name: ___________________________________ **Phone:** ________________________

Client Address: ____

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Complaint/Grievance Detail:
(*Provide a concise statement of facts related to the complaint/grievance, including dates and persons involved-attach a continuation page, if necessary*)

Remedy Sought by the Complainant/Grievance:
(*Be specific as to what resolution you are seeking*)

Send completed form to: Broward Regional Health Planning Council, Inc. 200 Oakwood Lane, Suite 100 Hollywood, FL 333020 – or- By Fax: (833) 297-2290 Attention: Cristy Kozla

……………………………………………………………………………………………….
For Office Use Only:

Date Complaint/Grievance Form Received: ____________________

Received By: ________________________

Premium Assistance
Insurance/Payment Decision Appeal Form

The Appeal Process is available **thirty (30) days** following the receipt of the denial decision.

Client Name: ____ **Phone:** __________________________________

Client Address: ____

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Complaint/Grievance Detail:
(Provide a concise statement of the reason you feel your application should have been approved. Attach a continuation page and/or supporting documentation if necessary.)

Remedy Sought by the Complainant/Grievance:
(Be specific as to what resolution you are seeking: You MUST provide NEW or ADDITIONAL information which does not conflict or contradict the information you previously provided.)

Send completed form to:

ATTN: Vice President of Programs
Broward Regional Health Planning Council, Inc.
200 Oakwood Lane, Suite 100, Hollywood, FL 33020

Or FAX: (833) 297-2290

For Office Use Only

Date Appeal Form Appeal Received: __________________ **Received By:** ____________________________________

Date Appeal Form Appeal Reviewed: __________________ **Decision:** ____________________________________