Kentucky Department for Medicaid Services
1915(c) Waiver Grievance Form

Once completed, please email form to 1915cwaiverhelpdesk@ky.gov or mail it to:
Department for Medicaid Services
Division of Community Alternatives
275 E. Main St., 6W-B
Frankfort, Kentucky 40621

Date

Name of Person Filing Grievance

Email Address

Phone Number

Check One:

□ I am a waiver participant.

□ I am filing a grievance on behalf of a waiver participant.*

***If filing on behalf of a waiver participant, please state your relationship to the individual:**

_____

Waiver Participant Information

Participant's Name

Participant's Address

Participant's Date of Birth

Participant's MAID Number

Please Explain Your Grievance
Click or tap here to enter text.

Please Explain Your Desired Outcome
Click or tap here to enter text.

Signature of Person Filing Grievance | **Date**

Information below to be completed by DMS staff.

Received By (Please Print Name) | **Date**