ATHENS COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Complaint of Programs, Services, Policies or Administrative Practices
Or
Appeal of Adverse Action

Name and signature of person filing complaint or appeal:		Print Name: Signature:	
Today's Date		Has the ACBDD provided you with a copy of the ACBDD Administrative Resolution of Complaint Policy and explained it to you?	☐ YES ☐ NO
Is this a formal or informal complaint or appeal?	☐ Formal ☐ Informal	Did the ACBDD offer/provide assistance to you in filing your complaint or appeal?	☐ YES ☐ NO
If applicable, please identify the complaint type (check all that apply):		☐ Complaint of ACBDD Program ☐ Complaint of ACBDD Services ☐ Complaint of ACBDD Policy ☐ Complaint of ACBDD Administrative Practices	
For what specific program, service, policy or administrative practice is the complaint?			
If applicable, please identify the appeal of adverse action type (check all that apply):		☐ Adverse action – denied request for a non-Medicaid service ☐ Adverse action – reduction of a non-Medicaid service ☐ Adverse action – suspension of a non-Medicaid service ☐ Adverse action – termination of a non-Medicaid service ☐ Adverse action – the outcome of an eligibility determination	
In the space below, please describe the specific action(s) for which you are filing a complaint or appeal.			
In the space below, please specify the outcome(s) or remedy you are expecting.			