DHCS DISCRIMINATION COMPLAINT FORM (TITLE VI AND ADA)

CONFIDENTIAL

Federal law states that all organizations receiving federal money must take steps to ensure that federal money is not used for a discriminatory purpose. Therefore all people and organizations providing Medi-Cal assistance in California must respect a consumer's rights and prohibit discrimination in the administration of Medi-Cal services (this includes the people and organizations determining Medi-Cal eligibility and Medi-Cal service providers). The Department of Health Care Services (DHCS) Office of Civil Rights (OCR) has established this complaint process for Medi-Cal consumers to voice complaints of alleged discrimination against any individual or organization that they believe has engaged in a prohibited discriminatory practice.

In regard to complaints of discrimination the complainant has a right to:

- File a written complaint with the Department of Health Care Services (DHCS) Office of Civil Rights (OCR) within three hundred sixty-five (365) days from the alleged unlawful discrimination. The written complaint must state the action perceived to be discriminatory, the basis of discrimination, and the specific remedy(ies) sought by the complainant

- File an Unruh Civil Rights complaint with the Department of Fair Employment and Housing (DFEH), the complainant is required to file such complaint within one (1) year from the alleged discriminatory act

- File a complaint under Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act (ADA) of 1990 and other applicable state and federal laws with both the federal Health and Human Services Office of Civil Rights (HHS OCR) and/or the DHCS OCR. A complainant is required to file a complaint within on-hundred-eighty (180) days from the alleged discriminatory act

- An impartial investigation

- Have a representative chosen and paid for by the complainant present at all stages of the process

- Be free from restraint, interference, coercion, or retaliation

- Ask the HHS OCR to review the action of the DHCS Office of Civil Rights

The complainant has a responsibility to:

Provide accurate and factual information during all phases of the complaint process.

I have read and understand these rights and responsibilities.

Signature	Date

CIVIL RIGHTS EXTERNAL COMPLIANCE PROGRAM
COMPLAINT OF DISCRIMINATION (TITLE VI and ADA)

Complete and return to:
Department of Health Care Services
Office of Civil Rights, MS 0009
PO Box 997413
Sacramento, CA 95899-7413

NAME	DATE
ADDRESS	E-MAIL ADDRESS
	PHONE NUMBER

I believe that I have been discriminated against on the basis of:

☐ RACE	☐ NATIONAL ORIGIN	☐ RELIGION	☐ AGE
☐ GENDER	☐ COLOR	☐ DISABILITY (including HIV Status)	☐ OTHER

NAME & ADDRESS OF MEDI-CAL ADMINISTRATOR/PROVIDER	NAME & TITLE OF PERSON COMPLAINED OF (Respondent)	DATE OF OCCURRENCE	PHONE NUMBER (Respondent)

Describe in your own words what action(s) have happened to lead you to believe you have been discriminated against.

Indicate what resolution you are seeking.

I understand the above information is true and complete to the best of my knowledge and belief.

COMPLAINANT'S PRINTED NAME	COMPLAINANT'S OR AUTHORIZED REPRESENTATIVE SIGNATURE	DATE