STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF HEALTH CARE SERVICES OFFICE OF CIVIL RIGHTS

# DHCS DISCRIMINATION COMPLAINT PROCESS (TITLE VI AND ADA)

# COMPLAINANT RIGHTS

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 one-hundred-eighty (180) 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 one-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 PO Box 997413, MS 0009 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 |