Division of Health Care Finance & Administration

Discrimination Complaint Form

Federal and State laws do not allow the Division of Health Care Finance and Administration ("HCFA") to treat you differently because of your:

● race ● color ● national origin ● disability ● age ● sex

● religion ● or any other status/group protected by law

HCFA is made up of these programs:

● TennCare ● CoverKids ● AccessTN ● HealthyTNBabies ● CoverRX

● Office of eHealth Initiatives ● Strategic Planning and Innovation Group

Do you think you have been treated differently for these reasons? Use these pages to report a complaint to HCFA.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.

Name _____

Address_____

_____ Zip _____

Telephone Home (_____)_____ Work or Cell (_____)_____

Email Address _____

Name of MCO/Health Plan_____

Name of HCFA Program: _____

2.* Are you reporting this complaint for someone else? Yes _____ No _____

If Yes, who do you think was treated differently because of their **race, color, national origin, disability, age, sex, religion, or any other group protected by law?**

Name_____

Address_____

_____ Zip _____

Telephone Home: (_____) _____ Work or Cell (_____) _____

How are you connected to this person (spouse, brother, friend)?

_____

Name of this person's MCO/Health Plan _____

3.* How do you think you were you treated in a different way? Was it your

Race_____ National Origin_____ Color____ Sex____

Age____ Disability_____ Religion ____ Other_____

4. What is the best time to talk to you about this complaint?_____

5.* When did this happen to you? Do you know the date?

Date it started _____ Date of the last time it happened _____

6. Complaints must be reported by 6 months from the date you think you were treated in a different way. You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

_____

_____

_____

7.* What happened? How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

_____

_____

_____

8. Did anyone see you being treated differently or is there anyone who would have more information about what happened? If so, please tell us his/her:

Name **Address** **Telephone**

_____

_____

_____

9. Do you have more information you want to tell us about?

_____

_____

_____

10.* We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the person is less than 18 years old, a parent or guardian should sign for the minor. **Declaration:** *I agree that the information in this complaint is true and correct and give my OK for HCFA to investigate my complaint.*

_____

(**Sign your name here if you are the person this complaint is for**) (Date)

_____

(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are **not** the person's Authorized Representative? Please sign your name below. **The person you are reporting this complaint for must sign above or must tell his/her health plan/ HCFA Contractor or HCFA that it is okay for them to sign for him/her. Declaration:** *I agree that the information in this complaint is true and correct and give my OK for HCFA to contact me about this complaint.*

_____

(Sign here if you reporting this for someone else) (Date)

Are you a helper from HCFA or the MCO/Health Plan/Contractor assisting the person in good faith with the completion of the complaint? If so, please sign below:

____

(Sign here if you are either a helper from HCFA or the MCO/Health Plan/Contractor) (Date)

It is okay to report a complaint to your MCO/Health Plan/ HCFA Contractor or HCFA. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail the completed, signed Complaint **and** the signed Agreement to Release Information pages to:

Office of Civil Rights Compliance (OCRC)
310 Great Circle Road; Floor 4W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673
Free ♦♦ gratis ♦♦ TRS ♦♦ **Call** ♦♦ llame ♦♦ 711 ♦♦ **Ask** ♦♦ pregunte 877-779-3103
HCFA.fairtreatment@tn.gov

Need free language help? Call ♦♦ Necesita ayuda con el idioma gratuita? Llame ♦♦
هل تريد مساعدة في اللغة مجاناً؟ اتصل ♦♦ 需要免费的翻译服务吗? 请致电♦♦ 무료로 통역 도움이 필요하십니까? 전화 ♦♦ Cần giúp đỡ miễn phí ngôn ngữ? Gọi ♦♦
تو يئ كئم ئه ندامي وپئتڤي اهريكاريا بئ به رامبەه ري؟ په يوه ندئي بكه ♦♦
Ma u baahan tahay gargaar luqadda oo bilaash ah so wac ♦♦ 855-259-0701 or 855-857-1673

Have a disability and need free help or an auxiliary aid or service (Braille, large print)? Call ♦♦
Tiene una discapacidad y necesita ayuda gratuita? Llame ♦♦ هل لديك اعاقة وتحتاج مساعدة مجانية؟ اتصل ♦♦
您是否因残障而需要免费的帮助呢? 请致电 ♦♦ 장애가 있으신 분으로서 무료 도움이 필요하십니까? 전화 ♦♦
Có khuyết tật và cần sự giúp đỡ miễn phí Gọi ♦♦
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Ma leedahay naafo oo u baahan tahay gargaar bilaash ah so wac ♦♦ 855-259-0701 or 855-857-1673

TN Division of Health Care Finance & Administration

Agreement to Release Information

To investigate your complaint, HCFA and your MCO/Health Plan or other HCFA Contractor may need to tell other persons or agencies important to this complaint your name or other information about you. HCFA is made up of these programs:

● TennCare ● CoverKids ● AccessTN ● HealthyTNBabies ● CoverRX

● Office of eHealth Initiatives ● Strategic Planning and Innovation Group

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

• I understand that during the investigation of my complaint HCFA and _____ (write name of your MCO/Health Plan or HCFA Contractor on the line) may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my color, my MCO/Health Plan may need to talk to my doctor.

• You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. But, if you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. And, we may have to close your case. However, before we close your case if your complaint can no longer be investigated because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to HCFA telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to my MCO/Health Plan or HCFA Contractor telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to HCFA without canceling your complaint. If you end the Release Agreement, it only applies to the future sharing of information. This will not change information that has already been shared about you. But we will not share any more information.

Signature: ____ Date: ________________________

Name (Please print): ____

Address: ____

Telephone: ____

Need help? Please contact or mail a completed, **signed** <u>Complaint</u> **and** a **signed** **<u>Agreement to Release Information</u>** form:

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HCFA.fairtreatment@tn.gov

If you change your mind and want to end the Release Agreement contact OCRC.

Need free language help? Call ♦♦ Necesita ayuda con el idioma gratuita? Llame ♦♦
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♦♦ Cần giúp đỡ miễn phí ngôn ngữ? Gọi ♦♦
♦♦ هكب ئيدن وي مپ؟ ير هبمار هب ئب ايراكيراه يڤتئپو يمادن ئه كئم ئي وت
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