

Discrimination Complaint

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 • 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
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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

You can also call us if you need help with this information.

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 • 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 Complaint and a signed Agreement to Release Information** form:

HCFA, 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

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

- **Do you need help talking with us or reading what we send you?**
- **Do you have a disability and need help getting care or taking part in one of our programs or services?**
- **Or do you have more questions about your health care?**

Call us for free at 1-855-259-0701. We can connect you with the free help or service you need. (For TTY call: 1-800-848-0298)

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Kurdish: کوردی

ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆرای، بۆ تو بەردەستە. پەیوەندی بە 1-855-259-0701 (TTY: 1-800-848-0298) بکە.

Arabic: العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم: 1-800-848-0298).

Chinese: 繁體中文

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701 (TTY 1-800-848-0298)。

Vietnamese: Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: አማርኛ

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ደደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298)።

Gujarati: ગુજરાતી

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).

Laotian: ພາສາລາວ

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-259-0701 (TTY: 1-800-848-0298).

German: Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).

Tagalog: Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).

Hindi:	हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।	
Serbo-Croatian:	Srpsko-hrvatski
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).	
Russian:	Русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).	
Nepali:	नेपाली
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298) ।	
Persian:	
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد. 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.	