FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Discrimination Complaint Form

If you believe that you have been the subject of discrimination on the basis of race, color, national origin, age, disability, or sex by the Agency for Health Care Administration or one of its contractors, you can file a complaint with the Agency. You may file a complaint for yourself or for someone else. Alternative means of filing complaints will be made available upon request. To ensure that all necessary information is captured, please complete this optional complaint form and return to:

Civil Rights Compliance Coordinator
Agency for Health Care Administration
Office of the General Counsel
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308
Fax: (850) 922-6484

Complainant Contact Information

Name: _____

Address: _____

_____

Telephone: _____

Medicaid ID # (if applicable): _____

Email: _____

Preferred method of contact: _____

____ Notify me about the outcome of this investigation

Or

____ Do **NOT** notify me about the outcome of this investigation

Authorized Representative Making Complaint (if different than complainant)

Name: _____

Address: _____

_____

Telephone: _____

Email: _____

Complaint No._____

(For official use only)

Discrimination Complaint Form

Preferred method of contact: _____

Relationship to complainant: _____

____ Notify me about the outcome of this investigation*****

Or

____ Do **NOT** notify me about the outcome of this investigation

***Please note**: if you are an Authorized Representative making a discrimination complaint on behalf of a complainant and wish to be notified as to the outcome of the complaint investigation, you must obtain a signed HIPAA authorization release form from the complainant. This document can be found at: http://ahca.myflorida.com/hipaa/pdf/HIPAAAuthorization.pdf

Complaint

Have you filed or do you intend to file a discrimination complaint related to this matter in another forum? ____ Yes ____ No

If yes, please indicate what agency or court? _____

Date of alleged discrimination: _____

Provide the name and address of the specific entity(ies), person(s), program(s) and/or facility(ies) the complainant believes is/are responsible for the discrimination and a brief description of the alleged acts of discrimination.

Complaint No._____
(For official use only)

Discrimination Complaint Form

Signature: _____

Date: _____

PRIVACY POLICY

Submitted information is maintained and destroyed according to the Florida Agency for Health Care Administration Notice of Privacy Practices. Copies of this notice can be viewed at: http://ahca.myflorida.com/hipaa/privacynotice.shtml

Complaint No._____

(For official use only)