Medication and Insurance Assistance Programs
Grievance Form

Instructions:

The use of this form is optional. You may submit a grievance in writing without using this form. Completing all sections of this form will help the California Department of Public Health (CDPH), Office of AIDS (OA), Medication Assistance Programs and Insurance Assistance Programs, to respond to your concerns in an efficient manner. Whether or not you use this form, we will take your concerns seriously, we will respond to you, and we will do our best to quickly resolve the issues you bring to our attention.

Contact Information:

Name: _____ Client ID # (if applicable): _____

Phone Number: _____

May we leave a message at this number? ☐ Yes ☐ No

If no, what is the best time of day to reach you? _____

Select all that apply:

- ☐ I am an ADAP Client
- ☐ I am an Enrollment Worker
- ☐ I am a Pharmacist
- ☐ I am a PrEP-AP Client
- ☐ I am a PrEP-AP Provider
- ☐ I am none of the above

Grievance Details:

Date of incident: _____

Who was involved in this incident (select all that apply)?

- ☐ OA Call Center Staff
- ☐ OA Staff
- ☐ Enrollment Worker
- ☐ Clinic/Clinician
- ☐ Pharmacy/Pharmacist
- ☐ Other
- ☐ Pool Administrators Inc. (PAI)
- ☐ Magellan Rx Management

Name of individual(s) and/or Enrollment Site involved (if applicable):

_____

Please describe your concerns, the actions or inactions that led to your dissatisfaction, and how you would like this incident to be resolved. If more space is needed, attach additional pages and any documentation in support of your grievance, if applicable.

Additional pages or supporting documentation attached?

☐ No ☐ Yes Number of additional pages_____

Type of supporting documents: _____

The information Practices Act of 1977 (California CC, Section 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (3)) require this notice to be provided when collecting personal information from individuals. The information requested on this form is requested by the California Department of Public Health, Office of AIDS, for purposes of identification and assisting us as we work to solve the problem you are contacting us to help you with. Furnishing the information requested on this form is voluntary. If you do not provide all the information requested on this form we will still try to assist you in solving your problem, but the missing information may delay or prevent us from solving the problem. The information requested on this form is used to identify who you are and what assistance we may provide to you, and to identify any obstacles that have delayed or prevented that assistance from being given.

Legal references authorizing maintenance of this information Health and Safety Code Sections 120950 through 120971; and Health and Safety Code Section 131085.

This information may be disclosed to OA contractors and providers if this is necessary or helpful as we work to address and resolve your concern. You have the right to review your own personal information maintained by the California Department of Public Health unless access is exempted by Law. You may request your own personal information by contacting the California Department of Public Health, Office of AIDS, at 1616 Capitol Avenue, Sacramento, CA 95814, MS 7700 P. O. Box 99726, Sacramento, CA 95899-7426.

Signature:_____ Date: _____