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Oregon Health Authority (OHA)
Report of Discrimination Form for the Public

Do you need help filling out this form?

Call 1-844-882-7889 toll-free or 711 (TTY) for help if you need:

- **An interpreter (a free service);**
- **This form in English, Spanish, Russian, Vietnamese, Simplified Chinese or Somali;**
- **This form in larger print, audio, braille or other format;**
- **Answers to your questions about this form.**

Do you want to report discrimination in one of the Oregon Health Authority's programs? If so, fill out this important form.

Please complete this form to report discrimination based on any of these factors:

- *Sexual orientation;*
- *Gender identity;*
- *Race;*
- *Color;*
- *National origin;*
- *Limited English proficiency;*
- *Religion;*
- *Disability;*
- *Age;*
- *Sex (gender);*
- *Pregnancy;*
- *Sexual harassment;*
- *Marital status;*
- *Retaliation for filing a report of discrimination; or*
- *Any other class protected by law (see Oregon Administrative Rules 943-005-0000 to 943-005-0070 for more information).*

The Oregon Health Authority (OHA) Office of Equity and Inclusion (OEI) will carefully review the information on this form.

You will get a letter from us no more than seven days after we receive the form. It will tell you that we got your report of discrimination and if OEI has the authority to act on it. If OEI cannot act on your report, we will tell you which office can act on it.

We may need your permission to use your name during an investigation. Please read, sign and turn in the OHA Authorization for Use and Disclosure of Information with your Report of Discrimination. (This authorization is found later in this document.)

It is OHA's policy not to intimidate, threaten, coerce, discriminate or retaliate against you for making a report of discrimination.

PLEASE NOTE:

Making a Report of Discrimination differs from asking for an appeal or a hearing if you receive a Notice of Action denying your health services. This Report of Discrimination is not connected to the Notice of Action or Notice of Appeal Resolution.

If you get a Notice of Action denying your request for health services, you can ask your CCO/health plan for an appeal, or you can ask OHA for a hearing, or both. You must send in your Hearings Request Form within **45 days** of the "date of notice."

For more information on appeals or hearings, see the Oregon Health Plan Client Tip Sheet 4 – Appeals and Hearings at https://apps.state.or.us/Forms/Served/he9040d.pdf. You can also contact the Oregon Health Plan Client Services Unit at 1-800-273-0557 or 711 (TTY).

Information about the Report of Discrimination

Please print or type — attach extra pages, if necessary.

Date:_____

1A. _____
Name of person who experienced alleged discrimination

_____ _____ _____ _____
Address City State ZIP code

_____ _____ _____
Home phone / cell phone Work phone Other

_____ _____ _____
Date of birth OHP # *(if applicable)* Preferred language

How would you like us to contact you? ☐ Phone ☐ Email ☐ Other

Best time to contact you:_____*(Day/time)*

May we contact you by email? ☐ Yes ☐ No Email:_____

If you are making this report of discrimination for someone else, please fill out the information below:

1B. _____
Name of person completing this form for person who experienced the alleged discrimination

_____ _____ _____ _____
Address City State ZIP code

_____ _____ _____
Home phone / cell phone Work phone Other

_____
Preferred language

How would you like us to contact you? ☐ Phone ☐ Email ☐ Other

Best time to contact you:_____*(Day/time)*

May we contact you by email? ☐ Yes ☐ No Email:_____

2. Please give us information about the individual/group/agency/office you believe discriminated.

Name*(s)* | Phone number *(if known)*

Agency or department name/ location of building or facility

Most recent date(s) of when alleged discrimination occurred

Did the alleged discrimination happen more than 180 days ago? ☐ Yes ☐ No
If yes, please tell us why you are making this Report of Discrimination now:

3. Were you denied access to a facility or building? ☐ Yes ☐ No

Building/facility name

Street address | City | State | ZIP code

4. Were you denied access to or participation in a program, service or activity? ☐ Yes ☐ No
If yes, please fill out the information below:

Program name

Date | Time

5. Tell us what happened. Please include the information below:

- A list of all the people involved, including first and last names and titles, if known;
- Exact words or actions of the people involved;
- Date(s);
- Time(s);
- Contact information, if known, for each individual.

6. Witnesses:
List the full name and contact information of anyone who may have seen or heard the alleged discrimination. Please provide as much information as possible.

7. Have you tried to solve the problem or contact anyone else with your report?
If yes, who have you contacted? What happened?

8. What would you like to see happen with this report?

9. Do you believe that your protected class was the reason for the discrimination?
☐ Yes ☐ No

If yes, please check all boxes that apply.

☐ Age	☐ Religion
☐ Disability	☐ Pregnancy
☐ Sex (gender)	☐ Sexual harassment
☐ Marital status	☐ Retaliation for filing a Report of Discrimination
☐ National origin	☐ Limited English proficiency
☐ Race	☐ Sexual orientation
☐ Color	☐ Gender identity

☐ Other:_____

NOTE: If your protected class (listed above) is not the reason for your discrimination report, we will send your report to the appropriate office.

This form was filled out by:

- ☐ The person against whom the alleged discrimination occurred
- ☐ Attorney/representative/advocate
- ☐ OHA employee:_____
- ☐ Other *(please specify)*:_____

The information on this form was gathered:

- ☐ By phone ☐ In person ☐ By email ☐ By fax
- ☐ Other *(please specify)*:_____

Please attach any other information related to your Report of Discrimination.

PLEASE RETURN THIS FORM TO:

OHA Office of Equity and Inclusion
Diversity, Inclusion and Civil Rights Manager
421 S.W. Oak St., Suite 750, Portland OR 97204
Fax 971-673-1330 or email OHA.PublicCivilRights@state.or.us
Toll-free phone number: 1-844-882-7889 (voice) or 711 (TTY)

You may also have the right to file a complaint with one of the following agencies within 180 days of the alleged discrimination:

U.S. Department of Justice Civil Rights Division
950 Pennsylvania Ave., N.W., Washington, D.C. 20530
www.justice.gov/crt/complaint/
1-888-736-5551 (voice) or 202-514-0716 (TTY)

Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019
Fax: 202-619-3818
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

You may also have a right to file a complaint within one year of the alleged discrimination with the:

Oregon Bureau Of Labor and Industries (BOLI)
800 N.E. Oregon St., Suite 1045, Portland, OR 97232
www.oregon.gov/boli/CRD/Pages/C_Crcompl.aspx
971-673-0764 (voice) or 711 (TTY)

Reset Print Instructions

DHS Oregon Department of Human Services

Authorization for Use and Disclosure of Information

Oregon Health Authority

This form is available in alternative formats including Braille, large print, computer disk and oral presentation.

Legal last name of client/applicant:	First:	MI:	Date of birth:
Other names used by client/applicant:			Case ID number:

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Section A

Release from one record holder: *(individual, school, employer, agency, medical or other provider)*	**Specific information to be disclosed:**	**Mutual exchange: Yes/No**

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol/drug diagnoses, treatment, referral:

Section B

Release to: ***(address required if mailed)*** **If releasing to a team, list members.**	**Purpose:**	**Expiration date or event*:**

***This authorization is valid for one year from the date of signing unless otherwise specified.**

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information without specific authorization.

Section C

Full legal signature of individual or authorized personal representative:	**Relationship to client:**	**Date:**
Name of staff person *(print)*:	**Initiating agency name/location:**	**Date:**
Full legal signature of agency staff person making copies:	**This is a true copy of the original authorization document.**	
Print staff person name:		

Required information for the client

To provide or pay for health services: If the Department of Human Services (DHS) or Oregon Health Authority (OHA) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be assessments, tests or evaluations.)* Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS or OHA program or service not acting as a health care provider

This is a voluntary form. DHS or OHA cannot condition the provision of treatment, payment or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using this form

1. **Terms used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS or OHA staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS or OHA staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing.
   Exception: Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS or OHA can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed and the purpose.

Redisclosure: Federal regulations (42 CFR part 2) prohibit making any further disclosure of alcohol and drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

Note: Oregon's health services and programs have been transferred from the Department of Human Services (DHS) to the Oregon Health Authority (OHA). DHS will continue to determine eligibility for many of the health programs, as well other programs administered by DHS.