Advanced Health

Coordinated Care Organization

289 LaClair St • Coos Bay, OR 97420
Phone 541-269-7400 • Fax 541-269-7147
Toll Free 800-264-0014

COMPLAINT PACKET

General Information

In this packet is a copy of Advanced Health's Complaint and Appeal policy. Please read it carefully and call us with any questions. It will answer many of your questions about the complaint procedure.

Forms Needed

If you decide to file a complaint you will need to fill out forms. Please fill out these forms as soon as possible. Please make sure that you fill out and sign the "Authorization for Use and Disclosure of Information" form. It will help Advanced Health gather the information needed to make a decision about your complaint. Please return it with your complaint to Advanced Health.

Your Privacy

Your privacy is very important. The information that Advanced Health receives about you is kept private. Your information can not be given out without your written permission. The information gathered will be used for the review of your complaint.

All information is kept private. However, OMAP may be given information at certain times allowed by law. This would be to allow for a full review of your complaint. Some federal and state laws may not allow Advanced Health to pass on certain information such as HIV/AIDS, mental health, and drug/alcohol treatment, or referral information.

Time Frame for Filing a Complaint

You are responsible for filing the complaint in a timely manner. If Advanced Health does not receive your completed "Complaint" packet back within 45 days your complaint will be considered "withdrawn". If you decide later that you still want to file the complaint you can still do so. Please complete the Complaint packet and send it to Advanced Health. We will re-open the investigation on your complaint and send you a "Notice of Resolution" once we are finished.

Expedited Review

If you feel that your medical problem cannot wait for the normal complaint process you may qualify for an "Expedited Review". Please contact Advanced Health for help at the phone number above.

Need Help? Have Questions?

Please call Advanced Health for help. Advanced Health can get you the help you need. This includes interpreter services or help to fill out the forms. Please call Advanced Health toll free at 1-800-264-0014. For TTY/TTD services please call 1-877-769-7400.

Advanced Health

Complaint Form

Advanced Health
289 LaClair Street, Coos Bay, OR 97420
541-269-7400 ♦ Toll Free: 800-264-0014
TTY/TTD: 800-769-7400
Fax: 541-269-2052

If you have a complaint about your Oregon Health Plan services, fill out this form and return it to Advanced Health using either the mailing address or fax number listed above. If you need help to complete this form, please call 1(800) 264-0014 or TTY/TTD line 1(877) 769-7400.

Provide the following information:

Your Name: _____ Your Phone Number: _____

OHP Member's Name (if you are not the member): _____

OHP Member's Medical ID Number: _____

I have a complaint (about an issue other than a Notice of Action). [ ] Yes [ ] No

Describe what happened. Provide any information that might help us investigate your complaint. Attach copies of any documents that might help explain what happened. Include any updated information that you think would help us in our review.

_____
_____
_____
_____
_____
_____
_____

What should be done about it?

_____
_____
_____
_____

Complaints are reviewed and normally resolved within 5 working days. However, in some cases it may take up to 30 days to resolve a complaint. You will be notified if your complaint can not be resolved within the normal 5 day timeframe.

For Advanced Health Use Only:

Date received ___/___/___ Tracking Number _____ Date Completed ___/___/___

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.