AdvancedHealth
Bridging the Future of Healthcare

289 LaClair St. | Coos Bay, OR 97420
Main: 541-269-7400 | Fax: 541-269-2052
Toll Free: 800-264-0014 | TTY: 877-769-7400
www.advancedhealth.com

Complaint Form and Information

How to Make a Complaint
Please tell us if you are unhappy with Advanced Health, your provider, or care services. We will try to make things better. You can call us, send a letter, or walk in. You can call Member Services at 541-269-7400 or 1-800-264-0014. You may also fill out this form. You can walk in, or mail us a letter at:

Advanced Health
Attn: Grievance Coordinator
289 LaClair Street Coos Bay, OR 97420

Your Privacy
Your privacy is very important. The information Advanced Health receives about you is kept private. Your information can not be given out without your permission. The information will be used for the review of your complaint. We have included the "Authorization for Use and Disclosure of Information" form. It will let Advanced Health gather information about your complaint. Please return it with your complaint to Advanced Health.

Who Can Represent You?
You may represent yourself during a complaint. You can also have someone else complain for you. For someone to complain for you, you must complete and sign the Authorization/Disclosure form.

Complaint Resolution
We must contact you via phone or writing within five business days. If we can't address it in five business days, we will send you a letter to explain why we need more time. We will address your complaint in writing 30 days or less.

If you do not agree with our response to your complaint you can:

- Call Member Services at 541-269-7400 or 1-800-264-0014, or
- Call OHP Client Services Unit at 800-273-0557, or
- Ask the OHA ombudsperson for help:
  - Toll-free: 877-642-0450 (TTY 711) Fax: 503-947-2341
  - Mail: 500 Summer St. N.E. Salem, Oregon 97301

Need Help? Have Questions?

Please call Advanced Health Member Services. We can get you the help you need. This includes interpreter services, braille, larger print, or help to fill out this form. We can be reached at 541-269-7400 or toll free at 1-800-264-0014. For TTY/TTD services please call 1-877-769-7400.

Complaint Form on Back

AdvancedHealth
Bridging the Future of Healthcare

Complaint Form

Member's Name: _____

Member's OHP ID # or Date of Birth: _____

Member's Phone Number: _____

Your Name (if you are not the member):_____

Your Phone Number:_____

Complaint: What happened? When did it happen? Who was involved? (Please attach any documents that might help us investigate the complaint.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Resolution Request: What would you like to see happen?

_____

_____

_____

_____

_____

_____

DHS Oregon Department of Human Services

Authorization for Use and Disclosure of Individual Information

Oregon Health Authority

Reset form | Save As | Print

(•) Print without instruction pages. ( ) Print with instruction pages included.

Legal last name of individual:	First name:	MI:	Date of birth:

Other names used by individual:

(•) Prime ID / ( ) Case number / ( ) SSN:

Legal last name of representative:	First name:	MI:

By signing this form below, I authorize the named record holder to disclose the following specific confidential information about me.*

RELEASE FROM

Release from one record holder: (*Individual, school, employer, agency, medical or other provider.*)

Full name: Address:

City, state and ZIP:

Email address: Phone number:

Specific information to be disclosed: (*Please be as detailed as possible. Requesting "all information" could delay the response.*)

Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information.***)

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

Alcohol/drug diagnoses, treatment, referral:

RELEASE TO

Release to: (*Address required if mailed.*)

Full name: Address:

City, state and ZIP:

Phone number: Email address:

Purpose of the requested use or disclosure:

Expiration date or event*: Mutual exchange: ( ) Yes ( ) No

ADD another **Release To** section | **REMOVE** the last **Release To** section

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

CLIENT ACKNOWLEDGMENT
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from DHS|OHA. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local DHS or OHA program or local branch office. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**
Full legal signature of individual or a person legally authorized to act on behalf of the individual:

Relationship to individual:	Phone number:	Date:

If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff person (*print*):	Initiating agency name/location:	Date:
Legal signature of agency staff certifying true copy:		
Initial and date if form has been copied:		

Required information for the individual

Declining to sign may:

- Prevent DHS and OHA from determining eligibility for programs administered by DHS and OHA.
- Affect the ability of DHS and OHA to refer and coordinate services with providers.
- Affect the ability of the individual to receive services if the purpose of this form is to provide information necessary to receive health services.
- Affect payment for services if DHS or OHA is a provider of or paying for health care services under the Oregon Health Plan or Medicaid Program and DHS or OHA require the authorization to get reimbursement.

Show instruction pages | Hide instruction pages

Nondiscrimination Policy

We must follow state and federal civil rights laws. We cannot treat people unfairly in any of our programs or activities because of a person's:

- Age
- Color
- Disability
- Gender identity
- Marital status
- National origin
- Race
- Religion
- Sex
- Sexual orientation

Everyone has a right to enter, exit and use buildings and services. They also have the right to get information in a way they understand.

We will make reasonable changes to policies, practices and procedures by talking with you about your needs.

To report concerns or to get more information, please contact us in one of these ways:

- Web: www.advancedhealth.com
  Email: customerservice@advancedhealth.com
- Phone: 541-269-7400 / 1-800-264-0014
- Mail: 289 LaClair St. | Coos Bay OR 97420

You also have a right to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights. Contact that office one of these ways:

- Web: www.hhs.gov | Email: OCRComplaint@hhs.gov
- Phone: 1-800-368-1019, 1-800-537-7697 (TDD)
- Mail: 200 Independence Ave., SW, Room 509F HHH Bldg. Washington, D.C. 20201

Language Access Statement

ENGLISH

You can get this document in other languages, large print, braille or a format you prefer free of charge.

Program/contact: Advanced Health
Phone: 541-269-7400 or 1-800-264-0014
Email: customerservice@advancedhealth.com

We accept all relay calls or you can dial 711.

ARABIC / اللغة العربية

يمكنكم الحصول على هذا المستند مجاناً في لغات أخرى، أو بخط كبير، أو بلغة البريل أو بصيغة تفضلونها.

البرنامج/ الاتصال: Advanced Health
هاتف: 541-269-7400 or 1-800-264-0014
البريد الإلكتروني (الإيميل): customerservice@advancedhealth.com

نستقبل جميع المكالمات الهاتفية المعمولة بواسطة خدمات الاتصال المكتوب (relay calls) أو يمكنكم الاتصال بالرقم 711.

BOSNIAN / BOSANSKI

Možete besplatno dobiti ovaj dokument na drugim jezicima, štampan velikim slovima, Brajevim pismom ili u formatu koji želite.

Program/kontakt: Advanced Health
Telefon: 541-269-7400 or 1-800-264-0014
E-pošta: customerservice@advancedhealth.com

Primamo sve specijalne telefonske pozive od ljudi sa problemima sa sluhom ili govorom ili možete birati 711.

BURMESE / မြန်မာ

ဤစာကို အခြားဘာသာစကားများ၊ ပုံနှိပ်စာလုံးကြီးများ၊ မျက်မမြင်များအတွက် ဘရေးလ် သို့မဟုတ် သင်ပိုနှစ်သက်သည့် ပုံစံတို့ဖြင့် အခမဲ့ရရှိနိုင်ပါသည်။

အစီအစဉ်/အဆက်အသွယ် - Advanced Health
ဖုန်းနံပါတ် - 541-269-7400 or 1-800-264-0014
အီးမေးလ် - customerservice@advancedhealth.com

တဆင့်ဆက်သွယ်သည့် ဖုန်းခေါ်ဆိုမှုများ အားလုံးကို ကျွန်ုပ်တို့ လက်ခံပါသည်။ သို့မဟုတ် 711 ကို သင်ဆက်နိုင်ပါသည်။

CAMBODIAN / ភាសាខ្មែរ

អ្នកអាចទទួលបានឯកសារនេះជាភាសាដទៃទៀត ជាអក្សរធំៗ អក្សរសំរាប់ជនពិការភ្នែក ក ប្រ ជាទម្រង់ណាមួយ ដែលអ្នកចង់បាន ដោយមិនគិតថ្លៃ ។

កម្មវិធី/ទាក់ទងទៅ: Advanced Health

ទូរស័ព្ទ: 541-269-7400 or 1-800-264-0014

អ៊ីមែល: customerservice@advancedhealth.com

យើងទទួលយកការសំយោគតាមទូរស័ព្ទបន្ត ឬអ្នកអាចចុចទៅលេខ 711 ។

CHUUKESE / CHUUKESE

Ke tongeni omw kopwe angei noum kapin ei taropwe, ese kamo, non fosun fonuom, ika non "large print" (weiweita ika mak mei kan mese watte), ika non "braille" (faniten ekewe mei chun), ika ren pwan ekoch sakkun pisekin ika angangen awewe.

Meeni pirokram/io kopwe poporaus ngeni: Advanced Health

Fon: 541-269-7400 or 1-800-264-0014

Email: customerservice@advancedhealth.com

Aipwe etiwa "relay calls", ika ke tongeni pwisin kori 7-1-1.

FARSI / فارسی

شما می‌توانید این متن را به زبان‌های دیگر، با حروف درشت، خط بریل یا فرمتی که می‌خواهید، به طور رایگان دریافت کنید.

برنامه/تماس: Advanced Health

تلفن: 541-269-7400 or 1-800-264-0014

ایمیل: customerservice@advancedhealth.com

ما تمام تماس‌های دریافتی را می‌پذیریم یا می‌توانید با شماره ۷۱۱ تماس بگیرید.

FRENCH / FRANÇAIS

Vous pouvez obtenir ce document, sans frais, en d'autres langues, en gros caractères, en braille ou dans un format de votre choix.

Programme/contact : Advanced Health

Téléphone : 541-269-7400 or 1-800-264-0014

Email : customerservice@advancedhealth.com

Nous acceptons tous les appels relais, ou bien vous pouvez composez le 711.

GERMAN / DEUTSCH

Sie können dieses Dokument kostenlos in verschiedenen Sprachen, extra großem Druck, Braille oder einem von Ihnen bevorzugten Format bekommen.

Programm/Kontakt: Advanced Health

Telefon: 541-269-7400 or 1-800-264-0014

E-Mail: customerservice@advancedhealth.com

Wir akzeptieren alle Relais-Anrufe oder Sie können 711 wählen.

JAPANESE / 日本語

この資料は、他の言語に翻訳されたもの、大型活字、点字、その他ご希望の様式で、無料で入手可能です。

プログラム／連絡先 Advanced Health

電話番号： 541-269-7400 or 1-800-264-0014

電子メール： customerservice@advancedhealth.com

全ての電話リレーサービスを受け付けていますが、711にお電話いただいても結構です。

KOREAN/한국어

본 문서는 다른 언어로도 제공되며, 큰 활자, 점자 등 귀하가 선호하시는 형식의 문서를 무료로 받아보실 수 있습니다.

프로그램/연락처: Advanced Health

전화번호: 541-269-7400 or 1-800-264-0014

이메일: customerservice@advancedhealth.com

청각/언어 장애인을 위한 통신중계 서비스 (relay calls)를 지원하고 있습니다. 또는 711 번으로 전화 주시기 바랍니다.

LAO / ລາວ

ທ່ານສາມາດໄດ້ຮັບເອກະສານນີ້ເປັນພາສາອື່ນ, ຕົວພິມຂະໜາດໃຫຍ່, ໜັງສືໄຫງ່ສຳລັບຄົນຕາບອດ ຫຼື ໃນຮູບແບບທີ່ທ່ານຕ້ອງການໄດ້ໂດຍບໍ່ເສັງຄ່າ.

ໂຄງການ/ຕິດຕໍ່: Advanced Health

ໂທຣະລັບ: 541-269-7400 or 1-800-264-0014

ອີເມວ: customerservice@advancedhealth.com

ພວກເຮົາຍອມຮັບການໂທສ່ຳລັບຄົນພິການ ຫຼື ທ່ານສາມາດໂທຫາ 711 ໄດ້.

MARSHALLESE / KAJIN MAJEL

Kwomaroñ bōk peba in ilo kajin ko jet, jeje kōn leta ko rekilep, ilo braille ak ilo bar juon wāween emmanlok ippam ejjelok woñāān.

Kōjelā in program/kepaake: Advanced Health

Telpon: 541-269-7400 or 1-800-264-0014

Email: customerservice@advancedhealth.com

Kōmij bōk aolep kallok in relay ak kwomaroñ jiburi 711.

OROMO [CUSHITE] / AFAAN OROMOO

Galmee kana afaanoota biraatiin, barreefama qube gurguddaatiin, bireelii ykn barreefana warra qaroo dhabeeyyii ykn haala atii barbaadduun kanfaltii malee argachu ni dandeessa.

Sagantaa/kontoraata: Advanced Health

Bilbila: 541-269-7400 or 1-800-264-0014

Imeelii: customerservice@advancedhealth.com

Waamicha bilbilaa hunda ni fudhanna ykn 711 irratti bilbilu ni dandeessa.

POHNPEIAN / LOKAIA EN POHNPEI

Komwi kak alehda doaropwe wet ni lokaia tohrohr akan, ni nting laud, braille (preili: nting ohng me masukun), de ni ehu mwohmw tohrohr me komw kupwurki, ni soh pweipwei oh soh isipe.

Pwurokirahm/koandak: Advanced Health

Nempehn Delepwohn: 541-269-7400 or 1-800-264-0014

E-mail: customerservice@advancedhealth.com

Se kin alehda koahl karos me lelohng reht de komw kak eker 711.

ROMANIAN / ROMÂNĂ

Puteți obține acest document în alte limbi, într-un font mărit, în limbajul Braille sau într-un alt format preferat, în mod gratuit.

Program/contact: Advanced Health

Telefon: 541-269-7400 or 1-800-264-0014

E-mail: customerservice@advancedhealth.com

Acceptăm toate apelurile prin serviciu de releu sau puteți suna la 711.

RUSSIAN / РУССКИ

Вы можете бесплатно получить текст этого документа на другом языке, набранный крупным шрифтом или шрифтом Брайля либо в предпочитаемом вами формате.

Название программы и контактное лицо: Advanced Health

Телефон: 541-269-7400 or 1-800-264-0014

Эл. почта: customerservice@advancedhealth.com

Мы отвечаем на любые вызовы по линии трансляционной связи; кроме того, вы можете набрать номер 711.

SIMPLIFIED CHINESE / 简体中文

您可以免费获得本文件的其他语言版本，或者大号字体、盲文及您所喜欢格式的版本。

计划/联系人：Advanced Health

电话：541-269-7400 or 1-800-264-0014

电子邮箱：customerservice@advancedhealth.com

我们会接听所有转接电话，或者您可以拨打 711。

SOMALI / SOOMAALI

Waxaad heli kartaa dokumentigan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee braille ama qaabka aaad doorbidayso oo lacag la'aan ah.

Barnaamijka/halka la iskala soo xiriirayo: Advanced Health

Telefoonka: 541-269-7400 or 1-800-264-0014

Email-ka: customerservice@advancedhealth.com

Waa aqbalnaa wicitaanada gudbinta oo dhan ama waxaad wici kartaa 711.

SPANISH / ESPAÑOL

Puede obtener este documento en otros idiomas, en letra grande, en braille o en un formato que usted prefiera sin cargo.

Programa/contacto: Advanced Health

Teléfono: 541-269-7400 or 1-800-264-0014

Correo electrónico: customerservice@advancedhealth.com

Aceptamos llamadas de retransmisión o puede llamar al 711.

THAI / ไทย

คุณสามารถขอรับเอกสารนี้เป็นภาษาอื่น เป็นตัวอักษรขนาดใหญ่ อักษรเบรลล์ หรือรูปแบบที่คุณต้องการโดยไม่ต้องเสียค่าใช้จ่าย

โปรแกรม/ผู้ติดต่อ: Advanced Health

โทรศัพท์: 541-269-7400 or 1-800-264-0014

อีเมล: customerservice@advancedhealth.com

เรายอมรับสายโทรเข้าแบบพิมพ์เข้าและพูดตามทุกสายหรือคุณสามารถเลือกกดหมายเลข 711

TRADITIONAL CHINESE / 繁體中文

您可以免費獲得本文件的其他語言版本，或者大號字體、盲人點字及您所喜歡格式的版本。

計畫/連絡人：Advanced Health

電話：541-269-7400 or 1-800-264-0014

電郵：customerservice@advancedhealth.com

我們會接聽所有傳譯電話，或者您可以撥打 711。

UKRAINIAN / УКРАЇНСЬКА

Ви можете отримати цей документ іншими мовами, великим шрифтом, шрифтом Брайля або в будь-якому форматі, якому ви надаєте перевагу.

Програма/контактна особа: Advanced Health

Телефон: 541-269-7400 or 1-800-264-0014

електронна пошта: customerservice@advancedhealth.com

Ми приймаємо всі виклики через службу комутованих повідомлень або ви можете набрати 711.

VIETNAMESE / TIẾNG VIỆT

Quý vị có thể có tài liệu này miễn phí bằng ngôn ngữ khác, bản in khổ lớn, chữ nổi hoặc một định dạng khác.

Chương trình/liên lạc: Advanced Health

Số điện thoại: 541-269-7400 or 1-800-264-0014

Email: customerservice@advancedhealth.com

Chúng tôi chấp nhận tất cả các cuộc gọi chuyển tiếp hoặc quý vị có thể bấm số 711.