DEPARTMENT OF Managed Health Care

# LANGUAGE ACCESS COMPLAINT FORM

If you feel we have been unable to serve you because of language or other communication barriers, the Department may be able to help. Please complete this form and mail to: Department of Managed Health Care, Equal Employment Opportunity Office, 980 9th Street, Suite 500, Sacramento, CA 95833.

| 1. PERSON MAKING COMPLAINT | |
|---|---|
| **Name:** | |
| **Address:** | |
| **Phone Number:** | |
| **Email:** | |
| **Is someone else helping you file this complaint?** Yes ☐ No ☐ If 'Yes', include their: First name: _____ Last name: _____ | |

| 2. COMPLAINT DETAILS | |
|---|---|
| **Date of Incident:** | |
| **Department/Agency:** | |
| **Location or Address:** | |
| **Language Access Issues:** | (Check all that apply)<br>☐ Lack of signs informing the public of translation services<br>☐ Lack of forms/materials in multiple languages<br>☐ Lack of bilingual personnel<br>☐ The interpreter(s) or translator(s) skills were not good (List their names, if known)<br>☐ The interpreter(s) made rude or inappropriate comments<br>☐ Other: _____ |
| **What language did you need assistance with?** | ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Russian<br>☐ Spanish ☐ Vietnamese ☐ Other: _____ |
| Brief Description: Attach additional pages if needed. | |

| 3. LANGUAGE ACCESS COMPLAINT FORM ASSISTANCE | |
|---|---|
| Did someone assist you in completing this form? | ☐ **Yes** (*input information below*)<br>☐ **No** (*leave blank*) |
| **Name:** | |
| **Organization:** | |
| **Phone Number:** | |
| **Email:** | |

*DEPARTMENTAL USE ONLY:*

| | |
|---|---|
| **Date Received:** | |
| **Action Taken:** | |
| **Action Outcome:** | |
| **Contact Person:** | |
| **Phone:** | |
| **Email:** | |