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Coos Health & Wellness
Together, Inspiring Healthier Communities

Coos Health & Wellness (CHW)
Report of Discrimination Form for the Public

Do you need help filling out this form?

Call 541-266-6700 or 711 (TTY) for help if you need:

- **An interpreter (a free service);**
- **This form in English and Spanish;**
- **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 Coos Health & Wellness'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).*

Coos Health & Wellness (CHW) 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 CHW has the authority to act on it. If CHW cannot act on your report, we will tell you which office can act on it.If you are dissatisfied with the response from CHW, you may submit a written request for reconsideration within 20 dats to Oregon Health Authority.

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

It is CHW'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
- ☐ CHW 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:

Coos Health & Wellness
281 LaClair St, Coos Bay, OR. 97459
Phone 541-266-6700
Fax 541-888-8726
TTY Relay 711, 1-800-735-2900 or 1-800-735-3896 (Esp)

REQUEST FOR RECONSIDERATION:

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)