Health Connector Language Access Complaint Form

Your information

Please fill in your name and contact information.

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Daytime phone number where you can be reached: _____

Who was allegedly discriminated against?

Please fill in the contact information for the person who was allegedly discriminated against (if different from above):

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Daytime phone number where you can be reached: _____

Relationship to this person: _____

Discrimination Information

Please tell us how you believe discrimination occurred. Select all that apply

☐ Lack of signs informing the public of translation services
☐ Lack of forms/materials in multiple languages
☐ Lack of bilingual personnel
☐ Other (Explain below)

People who may have discriminated against you

Please list any names, addresses and phone numbers of anyone who you allege may have discriminated against you.

PERSON	NAME	ADDRESS	PHONE NUMBER	DATE OF OCCURRENCE (MM/DD/YYYY)
1				
2				
3				

Discrimination basis

Please specify the basis or bases on which you believe you were discriminated against.

Remediation or relief

Please identify what remediation (correction) or relief you seek.

Other complaints filed

Have you or the person allegedly discriminated against filed a complaint about this matter with any other agency or organization?

☐ Yes ☐ No

If yes, please identify the name and location of the office(s) where the complaint was filed.

When was the complaint filed? (MM/DD/YYYY): _____

Your signature

We cannot accept a complaint if it has not been signed. Please sign (electronically or by hand) and date this complaint form below:

Signature: _____ Date: _____

Signature: _____ Date: _____

Note: If you are filing the complaint for someone else, you must also get that person to sign and date it.

How to file this complaint

Send a completed, signed and dated copy of all pages of the Health Connector's Language Access Complaint Form and any supporting documentation you want us to see, to:

Mailing Address: Attn: Compliance Manager
Massachusetts Health Connector Compliance Unit
P.O. Box 960189
Boston, MA 02196

Email Address: LanguageRights@state.ma.us

OPTIONAL SECTION

The remaining information on this form is optional. Not answering these does not affect the Health Connector's investigation into your complaint.

Special accommodations

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply):

☐ Braille ☐ Large Print ☐ CD with Word file ☐ Audio CD ☐ Electronic Mail ☐ TDD

☐ Sign language interpreter (specific language): _____

☐ Foreign language interpreter (specify language): _____

☐ Other (specify): _____

Ethnicity and language preference

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

Ethnicity (select one):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Ethnicity (select all that apply):

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White

☐ Other (specify): _____

Preferred Language (if other than English): _____