



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 95814.

1. PERSON MAKING COMPLAINT	
Name:	
Address:	
Phone Number:	
Email:	
Is someone else helping you file this complaint?	Yes or 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) Lack of signs informing the public of translation services <input type="checkbox"/> Lack of forms/materials in multiple languages <input type="checkbox"/> Lack of bilingual personnel <input type="checkbox"/> The interpreter(s) or translator(s) skills were not good (List their names, known) <input type="checkbox"/> The interpreter(s) made rude or inappropriate comments <input type="checkbox"/> Other: _____ <input type="checkbox"/>

2. COMPLAINT DETAILS

What language did you need assistance with?	Cantonese <input type="checkbox"/> Korean <input type="checkbox"/> Mandarin <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____ <input type="checkbox"/>
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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) <input type="checkbox"/> No (leave blank) <input type="checkbox"/>
Name:	
Organization:	
Phone Number:	
Email:	



DEPARTMENTAL USE ONLY:

Date Received:	
Action Taken:	
Action Outcome:	
Contact Person:	
Phone:	
Email:	