AIDS DRUG ASSISTANCE PROGRAM
GRIEVANCE FORM

The use of this form is optional. You may submit a grievance in writing without using this form. Completing all sections of this form will help the California Department of Public Health, Office of AIDS, AIDS Drug Assistance Program (CDPH/OA/ADAP), which includes the Medication Assistance Program and the Insurance Assistance Programs, to respond to your concerns in an efficient manner. Whether or not you use this form, we will take your concerns seriously, we will respond to you, and we will do our best to quickly resolve the issues you bring to our attention.

Contact Information:			
Name:		Phone Number:	
Is it ok to leave a message at this number?	☐ Yes ☐ No	If no, what is the best time of day to reach you?	
I am a (select one):			
☐ ADAP Client ☐ ADAP Enrollment Worker ☐ ADAP Coordinator ☐ Pharmacist ☐ OTHER_____			

Details of event that lead to your concern:			
Date of Event:		Enrollment Site: (if applicable)	
Who was involved in this incident?			
☐ ADAP Enrollment worker		☐ CDPH/ADAP Staff	
☐ PBM Contractor, Magellan Rx Management		☐ Pharmacy – Name/City: _____	
☐ IBM/MBM Contractor, Pool Administrators Inc. PA		☐ OTHER: _____	
Name of individual involved (if applicable):			

In the area below, describe the nature of your concern and the action (or inaction) that lead to filling out this form. Also, please share how you would like this situation to be resolved. *Add additional pages if needed and any documentation that supports your complaint.*

Are more pages being sent with this form?	☐ Yes ☐ No	*If yes, how many?*
Is a supporting document(s) attached?	☐ Yes ☐ No	*If yes, what?*

The Information Practices Act of 1977 (California CC, Section 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (E)(3)) require this notice to be provided when collecting personal information from individuals. The information requested on this form is requested by the California Department of Public Health, Office of AIDS, ADAP Branch, for purposes of identification and assisting us as we work to solve the problem you are contacting us to help you with. Furnishing the information requested on this form is voluntary. If you do not provide all the information requested on this form we will still try to assist you in solving your problem, but the missing information may delay or prevent us from solving the problem. The information requested on this form is used to identify who you are and what assistance we may provide to you, and to identify any obstacles that have delayed or prevented that assistance from being given.

Legal references authorizing maintenance of this information include Health and Safety Code Sections 120950 through 120971; and Health and Safety Code Section 131085.

This information may be disclosed to ADAP contractors and providers if this is necessary or helpful as we work to address and resolve your concern. You have the right to review your own personal information maintained by the California Department of Public Health unless access is exempt by law. You may request your own personal information by contacting the California Department of Public Health, Office of AIDS, at 1616 Capitol Avenue | Sacramento, CA 95814, MS 7700, P. O. Box 997426, Sacramento, CA 95899-7426.

_____ _____

Signature: Date:

Submit completed form to CDPH by Mail: MS 7700, PO Box 997426, Sacramento, CA 95899-7426;
ADAP Data Processing Unit Fax: 1-844-421-8008; or efax: cdphmedassistfax@cdph.ca.gov
If you have questions, please call CDPH at: 1-844-421-7050.