750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Grievance Form for Discrimination in a Health Program or Activity

General Instructions: Use this form if you believe the Maryland Health Benefit Exchange (MHBE) or a person or entity MHBE oversees has discriminated against you in the provision of a health program or activity, such as assistance in obtaining health-care coverage. Your grievance will be investigated internally by MHBE's Civil Rights Coordinator under Section 1557 of the Patient Protection and Affordable Care Act, with a right of appeal to the MHBE Executive Director. For information on how to file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, please see the Notice posted at Maryland Health Connection's website.

Grievance Information

_____
First MI Last Name

Preferred Method of Contact: (Check all that apply)

☐ Phone number (_____) _____-_____
Area Code

☐ Address: _____
Street Apt/Suite#

_____
City State Zip

☐ Email address: _____

Grievance Details - I believe that I have been discriminated against on the basis of (check):

☐ Race / Color / National Origin ☐ Age ☐ Sex ☐ Disability
☐ Other (Specify): _____

Who or what agency or organization do you believe discriminated against you?

Person or Agency/Organization? ☐ Person ☐ Agency/Organization

Name: _____
First MI Last

Address: _____
Street Apt/Suite#

_____
City State Zip

Phone (_____) _____- _____
Area Code

When do you believe that the civil rights discrimination occurred? _______________ _____
Month Day Year Time

Were there any witnesses? ☐ Yes ☐ No

Where did the alleged discrimination occur? _____

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible. (Attach additional pages or documents if needed.)

What corrective actions do you believe would address your concern?

Uses of Information

Filing a grievance with the Maryland Health Benefit Exchange ("MHBE") is voluntary. However, without the information requested above, MHBE may be unable to proceed with your grievance. We will use the information you provide to determine whether your grievance involves an MHBE health program or activity and, if so, how to investigate it. Information submitted on this form generally is treated confidentially. However, we reserve the right to disclose names or other identifying information about individuals when it is necessary for investigation of possible incidents of discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside MHBE for purposes associated with discrimination compliance and as permitted by law. MHBE will not intimidate, threaten, coerce, discriminate or retaliate against you for filing this grievance or for taking any action to enforce your civil rights. You are not required to use this form. You also may write a letter with the same information to the address found at the end of this form.

Consent

I agree that the Maryland Health Benefit Exchange ("MHBE") may collect and receive material and information about me, including personally identifiable information submitted in an application for health-care coverage, as well as medical records, which are relevant to its investigation of my grievance. To investigate my grievance, MHBE may need to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities. MHBE has my permission to use my name or other personally identifiable information, if necessary, to investigate my grievance. Consent is voluntary, and it is not always needed in order to investigate my grievance; however, failure to give consent is likely to impede the investigation of my grievance and may result in the closure of my case.

After reading the above, please check only one of the following:

☐ CONSENT: I have read, understand, and agree to the above and give permission to MHBE to reveal my identity or identifying information about me in my grievance file to relevant persons, agencies, or entities during any part of MHBE's investigation.

☐ CONSENT DENIED: I have read and I understand the above and do not give permission to MHBE to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my grievance and may result in closure of the investigation.

Signature:_____ Date: _____

Additional Information

The remaining information on this form is **optional**. Failure to answer these voluntary questions will not affect MHBE's decision to process your grievance.

Do you need special accommodations for MHBE to communicate with you about this grievance? (If yes, check all that apply)

☐ Foreign language interpreter (specify language): _____ ☐ Braille
☐ Large Print ☐ Sign language interpreter (specify language): _____
☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

Assister _____
First MI Last Name

☐ Phone number (_____) _____-_____ ☐ Email address: _____
Area Code

☐ Address: _____
Street Apt/Suite#

_____
City State Zip

Relationship to Grievant: _____

Have you filed your grievance or a complaint anywhere else? ☐ Yes ☐ No.
If yes, please provide the following information (Attach additional pages as needed):

Name of Person / Agency/ Court: _____
Date(s) Filed: _____
Case Number(s) (If known): _____

Please return the completed grievance form to the following address:

MD Health Benefit Exchange
Attn: Civil Rights Coordinator
750 E. Pratt Street, 6th Floor
Baltimore, MD 21202

Or, scan and email the completed grievance form to: MHCCivil.Rights@Maryland.gov