



Please complete this form and mail to:

Rachel Goldstein, ADA Compliance Officer  
Agency for Health Care Administration  
Office of the General Counsel  
2727 Mahan Drive, Mail Stop #3  
Tallahassee, Florida 32308

OR

Fax completed form to:

Fax: (850) 922-6484

Please Print Clearly

**Complainant Contact Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Medicaid ID # (if applicable) \_\_\_\_\_

Email \_\_\_\_\_

Preferred method of contact \_\_\_\_\_

Please do **NOT** contact me by \_\_\_\_\_

Notify me about the outcome of this investigation

Or

Do **NOT** notify me about the outcome of this investigation

**Authorized Representative Making Complaint (if different than complainant)**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Email \_\_\_\_\_

Complaint No. \_\_\_\_\_



Preferred method of contact \_\_\_\_\_

Please do **NOT** contact me by \_\_\_\_\_

\_\_\_\_ Notify me about the outcome of this investigation\*

Or

\_\_\_\_ Do **NOT** notify me about the outcome of this investigation

Relationship to complainant \_\_\_\_\_

**\*Please note:** if you are an Authorized Representative making an ADA complaint on behalf of a complainant and wish to be notified as to the outcome of the complaint investigation, you must obtain a signed HIPAA authorization release form from the complainant. This document can be found at: <http://ahca.myflorida.com/hipaa/pdf/HIPAAAuthorization.pdf>

**Complaint**

Have you filed or do you intend to file an ADA complaint related to this matter in another forum?

\_\_\_\_ Yes      \_\_\_\_ No

If yes, please indicate what agency or court? \_\_\_\_\_

Date of alleged discrimination \_\_\_\_\_

Provide the name and address of the specific entity(ies), person(s), program(s) and/or facility(ies) the complainant believes is/are responsible for the discrimination and a brief description of the alleged acts of discrimination.

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\_\_\_\_\_

Signature \_\_\_\_\_

Complaint No. \_\_\_\_\_  
(For official use only)



Date \_\_\_\_\_

**PRIVACY POLICY**

Submitted information is maintained and destroyed according to the Florida Agency for Health Care Administration Notice of Privacy Practices. Copies of this notice can be viewed at: <http://ahca.myflorida.com/hipaa/privacynotice.shtml>