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EDMUND G. BROWN JR.  
Governor

OFFICE OF AIDS  
Insurance Assistance Section

Management Memorandum  
Memorandum Number: 2014-03

DATE: February 28, 2014

TO: OFFICE OF AIDS-HEALTH INSURANCE PREMIUM PAYMENT  
(OA-HIPP) ENROLLMENT WORKERS

SUBJECT: INSURANCE ASSISTANCE SECTION (IAS) REQUEST FOR  
ASSISTANCE FORM AND PROCEDURES

The purpose of this memorandum is to inform all OA-HIPP Enrollment Workers (EWs) that formal procedures have been established for clients to request assistance regarding customer service issues. The procedures are intended to ensure that all requests are processed, investigated and resolved as quickly as possible and to ensure quality of service to all OA-HIPP and other IAS clients.

The IAS Request for Assistance Form allows the client to document their issue and provides the client with the information needed to submit the request. The form is also intended to allow for issue tracking from inception through resolution. The IAS Request for Assistance Form will be available on the IAS [webpage](#) and will be reviewed during future OA-HIPP EW trainings.

**Processes and Procedures:**

The Office of AIDS wants to insure prompt, courteous and considerate service to all persons applying for and enrolled in IAS programs. If a client has a customer service issue(s) the client should contact their OA-HIPP EW to try and resolve the issue through them first. If the OA-HIPP EW and client *are* unable to resolve the issue, they should use the following steps to resolve the matter.

1. The OA-HIPP EW and/or client should try to resolve the issue with the assistance of the assigned OA staff person concerned whenever possible.

2. If the issue is not resolvable at the staff level, the client may document the issue on the IAS Request for Assistance Form and forward it to the Office of AIDS. The forms are to be sent to: The Office of AIDS via **Fax: 916-440-5490** or **mail to: P.O. Box 997426, Sacramento, CA 95899-7426** with Attn: Request for Assistance. If documents are mailed, the envelope should be marked "confidential."
3. The issue will be investigated considering the information provided by all parties. The facts and documentation will be reviewed objectively and fairly. All parties involved will be interviewed and the Office of AIDS will work to resolve the issue.

Please contact your OA-HIPP staff person if you have any questions regarding these procedures.

Thank you,

A handwritten signature in black ink, appearing to read 'RM', with a long horizontal flourish extending to the right.

Richard Martin, Chief  
Insurance Assistance Section  
Office of AIDS



## INSURANCE ASSISTANCE SECTION REQUEST FOR ASSISTANCE FORM



The use of this form is optional, and you may submit a request for assistance in writing without using this form. Using this form will help the California Department of Public Health, Office of AIDS, Insurance Assistance Section respond to your concerns more quickly, since it will help avoid delays by giving us all the information normally needed to investigate and resolve concerns. 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.

**Client Contact Information:**

|   |  |   |  |
|---|--|---|--|
| Client Name:                                |  | Phone Number:                                     |  |
| Is it ok to leave a message at this number? | Yes <input type="checkbox"/> No <input type="checkbox"/> | If no, what is the best time of day to reach you? |  |
| Enrollment Worker Name:                     |  | Phone Number:                                     |  |

**Details of event that lead to your concern:**

|   |  |                                  |  |
|---|--|----------------------------------|--|
| Date of Event:  |  | Enrollment Site: (if applicable) |  |
| Name of Enrollment Worker or IAS staff member involved (if applicable): |  |                                  |  |

|   |   |
|---|---|
| <b>Please check the following boxes that may apply to your concern:</b> | <input type="checkbox"/> Untimely Application Processing <input type="checkbox"/> Eligibility Issues<br><input type="checkbox"/> Termination <input type="checkbox"/> Late Payment(s)<br><input type="checkbox"/> Unsatisfactory Customer Service |
|---|---|

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 <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, how many?</i> _____ |
| Is a supporting document(s) attached?     | Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, what?</i> _____     |

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, Insurance Assistance section, 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 health insurance premium payment 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 used to contact the health insurance provider and may be disclosed to that health insurance provider if this is necessary or helpful as we work to find a solution to help solve your problem. You have the right to review your own personal information maintained by the California Department of Public Health unless access is exempt by law. Contact the California Department of Public Health, Office of AIDS, OA-HIPP program, 1616 Capitol Avenue | Sacramento, CA 95814, MS 7700, P. O. Box 997426, Sacramento, CA 95899-7426.

I have discussed the concern as written above with an IAS staff member but am not satisfied with the resolution provided. I therefore wish to elevate this issue by submitting this Request for Assistance.

|                   |       |
|-------------------|-------|
| Client Signature: | Date: |
|-------------------|-------|