

OHA Certified Traditional Health Worker Complaint Form

This form is for use by the public



Please fill out as much information as you can. Attach copies of documents that help explain or support your complaint. If you need to, continue on the back of this form or attach extra pages.

PLEASE RETURN THIS FORM TO:

**OHA Office of Equity and Inclusion
Diversity, Inclusion and Civil Rights Manager
421 S.W. Oak St., Suite 750, Portland OR 97204**

Fax: 971-673-1330 or email: THW.Complaints@state.or.us
Toll-free phone number: 1-844-882-7889 (voice) or 711 (TTY)

This form can be made available in other languages, braille, large print, audio or other format. Please call 844-882-7889 (voice) or 711 (TTY) for help.

1. Your information *(Please print or type)*

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Home/cell phone: _____ Work phone: _____ Other: _____

Preferred language: _____

How would you like us to contact you? Phone Email Other

Best time to contact you: _____ (Day/time)

May we contact you by email? Yes No Email: _____

2. Traditional Health Worker's information

- Select worker type: Community Health Worker (CHW)
 Family Support Specialist (FSS)
 Peer Support Specialist (PSS)
 Peer Wellness Specialist (PWS)
 Person Health Navigator (NAV)
 Youth Support Specialist (YSS)
 Doula
 Other:

Name: _____ Employer, if known: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Home/cell phone: _____ Work phone: _____ Other: _____

3. Office or location of services

Name of office or location of services: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Date: _____ Time: _____

4. Tell us what happened

Attach copies of any documents that help explain or support your complaint.

List all the people involved, including first and last names, titles, and contact information, if known

Name:		
Title:		
Address:		
City:	State:	ZIP code:
Home/cell phone:	Work phone:	Other:

Name:		
Title:		
Address:		
City:	State:	ZIP code:
Home/cell phone:	Work phone:	Other:

Name:		
Title:		
Address:		
City:	State:	ZIP code:
Home/cell phone:	Work phone:	Other:

5. Have you been in contact with other people or agencies about your complaint?

If so, please provide full names(s) and contact information

Name:		
Address:		
City:	State:	ZIP code:
Home/cell phone:	Work phone:	Other:

If you **have not** contacted anyone, enter "N/A":

Tell us what happened since you made the complaint: