



DIVISION OF HIV AND STD PROGRAMS

600 South Commonwealth Avenue, 10th Floor
Los Angeles, California 90005

Customer Support Program

The Division of HIV and STD Programs' (DHSP) Customer Support Program (CSP) aims to assist consumers of HIV and STD services who have experienced difficulty accessing services from DHSP-funded providers throughout Los Angeles County. If you have a concern regarding your HIV or STD services that you have not been able to resolve with the provider directly, please feel free to share with us by completing the form below.

You can email us directly at dhspgrievance@ph.lacounty.gov or contact us by phone at **(800) 260-8787**. Please feel free to reach out with any questions or if you need further assistance.

What happens after I report a complaint or concern?

DHSP staff will contact you regarding your concerns within 2 business days of receipt of your form or message. We will then work closely with you and can provide assistance with seeking resolutions such as by filing a grievance with the service provider or by providing referrals or information about available services that will meet your needs. You will also be welcome to remain unidentified through the process if you prefer.

Customer Support Program

Client Complaint Form

Filing Date:														
YOUR INFORMATION														
Name (First, Middle and Last):		Patient/Client Name if different from complainant:												
Street Address:	City:	Zip Code:												
Phone Number and E-mail:		Can we leave a voice message? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Can we share your name with the agency? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Language:												
Preferred Pronouns: <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/> Other: _____														
Which is the best way to keep in touch with you? <input type="checkbox"/> Phone call <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Any/ No preferences <input type="checkbox"/> No written communication from us (DHSP) <input type="checkbox"/> Other: _____														
COMPLETE IF AUTHORIZING A REPRESENTATIVE TO FILE A COMPLAINT ON YOUR BEHALF														
Name of Representative:	Relationship to Patient/Client:	Phone Number:												
<input type="checkbox"/> I authorized the person or entity named above to serve as my representative for this complaint.														
SERVICE PROVIDER/AGENCY INFORMATION														
Agency Name:														
Service Location Address:	City:	Zip Code:												
Service Category: <table border="0" style="width: 100%;"><tr><td><input type="checkbox"/> Medical Care</td><td><input type="checkbox"/> Medical Case Management</td></tr><tr><td><input type="checkbox"/> Dental Care</td><td><input type="checkbox"/> Benefits Specialty</td></tr><tr><td><input type="checkbox"/> Mental Health</td><td><input type="checkbox"/> Legal Services</td></tr><tr><td><input type="checkbox"/> Nutrition/ Food Support</td><td><input type="checkbox"/> Residential Facility</td></tr><tr><td><input type="checkbox"/> HIV/ STD Testing</td><td><input type="checkbox"/> Transportation</td></tr><tr><td><input type="checkbox"/> PrEP Services</td><td><input type="checkbox"/> Other: _____</td></tr></table>			<input type="checkbox"/> Medical Care	<input type="checkbox"/> Medical Case Management	<input type="checkbox"/> Dental Care	<input type="checkbox"/> Benefits Specialty	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Nutrition/ Food Support	<input type="checkbox"/> Residential Facility	<input type="checkbox"/> HIV/ STD Testing	<input type="checkbox"/> Transportation	<input type="checkbox"/> PrEP Services	<input type="checkbox"/> Other: _____
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<input type="checkbox"/> PrEP Services	<input type="checkbox"/> Other: _____													
Did you file a complaint with the agency? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____ With Whom? _____ What was the result?														

COMPLAINT DETAILS

Complaint Type (Check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Ability to Get Care/ Service (i.e., denial, scheduling) | <input type="checkbox"/> HIV Patients' Rights Violation |
| <input type="checkbox"/> Billing | <input type="checkbox"/> Quality of Care (i.e., substandard care) |
| <input type="checkbox"/> Confidentiality and Privacy | <input type="checkbox"/> Medical Provider Issues |
| <input type="checkbox"/> Enrollment/ Benefits | <input type="checkbox"/> Staff Issues/ Customer Service |
| <input type="checkbox"/> Eviction | <input type="checkbox"/> DHSP Staff |
| <input type="checkbox"/> Facility Environment/ Accommodations | <input type="checkbox"/> Other: _____ |

Please describe your complaint. Attach additional pages or supporting documents.

When did this happen (date of incident)?

Name of person involved?

Name of person witnessed the incident?

What happened?

Desired Outcome (what would reasonably resolve this concern for you)?

YOU CAN SUBMIT A COMPLAINT OR CONCERN TO DHSP'S CUSTOMER SUPPORT UNIT BY:

● Email: dhspgrievance@ph.lacounty.gov ● Phone: (800) 260-8787

● In-person or by U.S. Mail:

Division of HIV and STD Programs

Attention: Grievance Coordinator

600 S. Commonwealth Avenue, 10th Floor, Los Angeles, California, 90005