



Discrimination Complaint Form

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

Complete this form if you believe that MassHealth has discriminated against you or treated you unfairly based on your race, color, national origin, age, disability, religion, sexual orientation, or sex (including gender identity, pregnancy, childbirth, and related medical conditions). You may submit a complaint for yourself or for someone else.

Instructions on how to submit the complaint and request additional assistance are outlined at the end of this form. Note: We may contact you and other relevant individuals or entities when investigating your complaint.

Please type or clearly print.

First name _____ Last name _____

Mailing street address _____

City _____ State _____ Zip _____

E-mail (if available) _____ Phone number _____

Date of birth or MassHealth ID number _____

Are you submitting this complaint for someone else? ☐ Yes ☐ No

If yes, who? _____

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race/Color/National Origin

☐ Age

☐ Disability

☐ Religion

☐ Sexual orientation

☐ Sex (including gender identity, pregnancy, childbirth, and related medical conditions)

☐ Other (specify): _____

When do you believe that the discrimination occurred?

List date(s). _____

Where within the MassHealth agency do you believe that the discrimination occurred?

Describe briefly what happened. How and why do you believe that you have been (or someone else has been) discriminated against?

Please be as specific as possible. Attach additional pages as needed.

I understand that by submitting this form I am filing a discrimination complaint with the MassHealth agency. I certify that the information I have provided on this form is true to the best of my knowledge.

Signature _____ Date (mm/dd/yyyy) _____

Do you need any of the following communication aides?

- ☐ Sign language interpretation (specify type) _____
- ☐ Language interpretation (specify language) _____
- ☐ Other (specify): _____

To submit a complaint, send a signed copy by mail, fax, or e-mail to the Section 1557 Compliance Coordinator.

By Mail: Section 1557 Compliance Coordinator
 1 Ashburton Place, 10th Floor
 Boston, MA 02108

By Fax: 617-889-7862

By E-mail: Section1557Coordinator@state.ma.us

If you need help submitting this form or need alternative formats, contact the Compliance Coordinator by phone at (617) 573-1704, TDD/TTY: 711 or (617) 573-1696; by fax at (617) 889-7862; or by email at Section1557Coordinator@state.ma.us.