

**EXPEDITED REVIEW REQUESTED****DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)****CIVIL RIGHTS DISCRIMINATION COMPLAINT**Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

YOUR FIRST NAME Scott		YOUR LAST NAME Schoettes	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code) (312) 663-4413	
STREET ADDRESS 105 W. Adams St. Suite 2600		CITY Chicago	
STATE IL	ZIP 60603	E-MAIL ADDRESS (If available) sschoettes@lambdalegal.org	

Are you filing this complaint for someone else? ☒ Yes ☐ No
If Yes, whose civil rights do you believe were violated?

FIRST NAME Lambda Legal Defense & Education Fund, Inc. and	LAST NAME AIDS Law of Louisiana, a program of the NO/AIDS Task Force
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I believe that I have been (or someone else has been) discriminated against on the basis of:

- ☐ Race / Color / National Origin ☐ Age ☐ Religion ☐ Sex
☒ Disability ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?
PERSON/AGENCY/ORGANIZATION

Blue Cross and Blue Shield of Louisiana

STREET ADDRESS 5525 Reitz Ave.		CITY Baton Rouge
STATE Louisiana	ZIP 70809	PHONE (Please include area code) 2252952054

When do you believe that the civil right discrimination occurred?

LIST DATE(S)

On or around 1/1/14 to the present

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)

Please see attached complaint.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE

DATE (mm/dd/yyyy)

02/10/2014

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at:

www.hhs.gov/ocr/civilrights/complaints/index.html. To mail a complaint see reverse page for OCR Regional addresses.

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

- ☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD
- ☐ Sign language interpreter (specify language): _____
- ☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME Kenneth		LAST NAME Upton	
HOME PHONE (Please include area code) 2146730858		WORK PHONE (Please include area code) 2142198585	
STREET ADDRESS 3500 Oak Lawn Avenue, Ste 500		CITY Dallas	
STATE TX	ZIP 75219	E-MAIL ADDRESS (If available) kupton@lambdalegal.org	

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

NO - N/A

DATE(S) FILED	CASE NUMBER(S) (If known)
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To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)	RACE (select one or more)
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English) _____

How did you learn about the Office for Civil Rights?

- ☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer
- ☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.

Region I - CT, ME, MA, NH, RI, VT Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	Region V - IL, IN, MI, MN, OH, WI Office for Civil Rights, DHHS 233 N. Michigan Ave. - Suite 240 Chicago, IL 60601 (312) 886-2359; (312) 353-5693 (TDD) (312) 886-1807 FAX	Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions Office for Civil Rights, DHHS 90 7th Street, Suite 4-100 San Francisco, CA 94103 (415) 437-8310; (415) 437-8311 (TDD) (415) 437-8329 FAX
Region II - NJ, NY, PR, VI Office for Civil Rights, DHHS 26 Federal Plaza - Suite 3312 New York, NY 10278 (212) 264-3313; (212) 264-2355 (TDD) (212) 264-3039 FAX	Region VI - AR, LA, NM, OK, TX Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
Region III - DE, DC, MD, PA, VA, WV Office for Civil Rights, DHHS 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499 (215) 861-4441; (215) 861-4440 (TDD) (215) 861-4431 FAX	Region VII - IA, KS, MO, NE Office for Civil Rights, DHHS 601 East 12th Street - Room 248 Kansas City, MO 64106 (816) 426-7277; (816) 426-7065 (TDD) (816) 426-3686 FAX	
Region IV - AL, FL, GA, KY, MS, NC, SC, TN Office for Civil Rights, DHHS 61 Forsyth Street, SW. - Suite 16T70 Atlanta, GA 30303-8909 (404) 562-7886; (404) 562-7884 (TDD) (404) 562-7881 FAX	Region VIII - CO, MT, ND, SD, UT, WY Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	Region X - AK, ID, OR, WA Office for Civil Rights, DHHS 2201 Sixth Avenue - Mail Stop RX-11 Seattle, WA 98121 (206) 615-2290; (206) 615-2296 (TDD) (206) 615-2297 FAX

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. Please do not mail complaint form to this address.

HHS-699 (7/09) (BACK)



COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.



- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.
- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☒ **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: Scott Schoettes Date: 02/10/2014
*Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

Name (Please print): Scott Schoettes

Address: 105 W Adams St, Ste 2600, Chicago, IL 60603

Telephone Number: 312-663-4413