Santa Clara Family Health Plan

Mail the completed form to get a $15 Target gift card*

**INSTRUCTIONS:**

1. Get a Pap test between July 1, 2014 and June 30, 2017.
2. Complete the **MEMBER INFORMATION** section below.
3. Complete the **DOCTOR INFORMATION** section below. Have your doctor sign and date.
    a. If you schedule a new appointment, be sure to take this form with you to get your doctor's signature.
    **OR**
    b. If you're unable to get your doctor's signature, call your doctor's office and ask them to fax or mail us a copy of your Pap test.
4. Return the completed form to us using the enclosed envelope.

We must receive the completed form with your doctor's signature **or** a copy of your Pap test before August 31, 2017 to send you the gift card.

**MEMBER INFORMATION:**

Your Name:_____ SCFHP ID #: _____

Date of Birth:_____ Phone #: _____

Your Mailing Address:_____

**DOCTOR INFORMATION:**

Doctor's Name:_____ Location Name:_____

Date of Pap Test:_____

Doctor's Signature:_____

Date Signed:_____

**Return this form in the enclosed envelope or mail to:**

Santa Clara Family Health Plan
PO BOX 5580
San Jose, CA 95150-9901

Or fax this form to: **1-408-874-1461**

***Target gift card not to be used for purchase of tobacco, alcohol, or firearms.**

50155E CCS 2017_03

Santa Clara
Family Health Plan

# Discrimination is Against the Law

Santa Clara Family Health Plan (SCFHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCFHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Grievance and Appeals Manager.

If you believe that SCFHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Attn: Grievance and Appeals Manager
Santa Clara Family Health Plan
210 East Hacienda Avenue
Campbell, CA 95008
Phone: 1-800-260-2055
TTY/TDD: 1-800-735-2929 or 711
Fax: 1-408-874-1962
Email: GrievanceDepartment@scfhp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Grievance and Appeals Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019
TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# Language Assistance Services

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-260-2055. (TTY: 1-800-735-2929 or 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-260-2055 (TTY: 1-800-735-2929 o 711).

**Chinese:** 注意：如果您说中文，将为您提供免费的语言服务。请致电 1-800-260-2055。（TTY：1-800-735-2929 或 711）。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-260-2055 (TTY: 1-800-735-2929 hoặc 711)

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-260-2055 (TTY: 1-800-735-2929 o 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-260-2055(TTY: 1-800-735-2929 또는 711)번으로 전화해 주십시오.

**Armenian:** ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-260-2055 (TTY (հեռատիպ)՝ 1-800-735-2929 կամ 711).

**Persian, Farsi:**
**توجه:** اگر به زبان فارسی صحبت می کنید، کمک در زمینه زبان به صورت رایگان در اختیارتان قرار خواهد گرفت. با 2055-260-800-1 (TTY 2929-735-800-1 یا 711) تماس بگیرید.

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-260-2055 (телетайп: 1-800-735-2929 или 711).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-260-2055（TTY: 1-800-735-2929 または 711）まで、お電話にてご連絡ください。

**Arabic:**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-260-2055 (رقم الهاتف النصي: 1-800-735-2929 أو 711).

**Punjabi:** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹਾਂ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ।

1-800-260-2055 (TTY: 1-800-735-2929 ਜ 711) ਤੇ ਕਾਲ ਕਰੋ।

**Mon-Khmer, Cambodian:** ប្រមែយកចិត្តទុកដាក់៖ ប្រសិនបើលោកអ្នកនិយាយ ភាសាខ្មែរ នោះលោកអ្នកអាចស្វែងរកសេវាជំនួយផ្នែកភាសា បានដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 1-800-260-2055 (TTY៖ 1-800-735-2929 ឬ 711)។

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-260-2055 (TTY: 1-800-735-2929 los sis 711).

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-260-2055 (TTY: 1-800-735-2929 या 711) पर कॉल करें।

**Thai:** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-260-2055 (TTY: 1-800-735-2929 หรือ 711).