GENERAL SERVICES AGENCY
OFFICE OF LABOR STANDARDS ENFORCEMENT
Patrick Mulligan, Director

Health Care Security Ordinance (HCSO) Complaint Form

Please return this form
by mail to: OLSE, City Hall Room 430, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102,
by fax to: (415) 554-6291, *attn: HCSO*, or
by email to: HCSO@sfgov.org.

Leave any field blank if the question is not applicable or if you don't know the answer.
Please attach additional sheets if necessary.

Claimant Information

Name		
Address (street and number, city, state, zip)		
Email Address	Phone: ○ Cell ○ Home	Phone: ○ Cell ○ Home
Briefly describe why you are submitting this complaint (for example, "I'm not receiving any health care benefits from my employer"):		

Employer Information

Name of employer		
Type of business ("restaurant," "manufacturing," etc.)		
Address where you work/worked (street and number, city, state, zip)		Approximately how may employees work at this location?
Does this business have other locations <u>in</u> San Francisco? ○ Yes ○ No ○ I'm not sure	Does this business have other locations <u>outside</u> San Francisco? ○ Yes ○ No ○ I'm not sure	
Name, title, and contact information (phone and/or email address) of owner or manager		

About Your Job

Provide your job title and/or briefly describe your duties (for example, "cook" or "cashier").		
When was your first day of work?	How much are you paid?	How may hours per week do you usually work?
Do you still work for this employer? ○ Yes ◉ No If no, provide your last date of work describe why you are no longer working for this employer:		

Exemptions and Waivers

Are you eligible for Medicare (federal health care benefits for people over 65 or with certain disabilities)? ○ Yes ◉ No ○ I'm not sure	If yes, what date (month and year) did your Medicare eligibility begin?
Are you eligible for TRICARE/CHAMPUS (federal health care benefits for active duty and retired military)? ○ Yes ◉ No ○ I'm not sure	If yes, what date (month and year) did your TRICARE/CHAMPUS eligibility begin?
Have you ever waived your right to health care expenditures under the Health Care Security Ordinance? ○ Yes ○ No ○ I'm not sure	If yes, when did you waive your right to health care expenditures?
Are you receiving health care services through another employer (either as an employee or as the spouse, domestic partner, or child of another person)? ○ Yes ○ No ○ I'm not sure	If yes, when did this other coverage begin?
Have you ever declined an offer from your employer for employer-provided health insurance? ○ Yes ○ No ○ I'm not sure	If yes, when did you decline this offer?

Health Insurance

Have you received health insurance from this employer during the past 3 years? ○ Yes ○ No ○ I'm not sure ***If <u>No</u>, skip the remainder of this section.***	
What date (month and year) did your coverage begin?	*If applicable*, what date did your coverage end?
If you know, how much did/does your employer pay (per month) for this coverage?	How much did/do you pay (per month) for this coverage?

Healthy San Francisco

Have you been enrolled in "Healthy San Francisco" during the past 3 years? ◯ Yes ◯ No ◯ I'm not sure ***If No, skip the remainder of this section.***	
What date (month and year) did your enrollment begin?	*If applicable*, what date did your enrollment end?
Did/does your employer pay into Healthy San Francisco on your behalf? ◯ Yes ◯ No ◯ I'm not sure	

Reimbursements for Health Care Expenses

Has this employer had a program to reimburse you for your health care expenses during the past 3 years? ◯ Yes ◯ No ◯ I'm not sure ***If No, skip the remainder of this section.***	
What date (month and year) did this program begin?	*If applicable*, what date did the program end?
Were you provided any information, verbally or in writing, about how to use the program? ◯ Yes ◯ No ◯ I'm not sure If yes, please describe the information you were provided:	
Are there any limitations or restrictions on the type of health care expenses that will be reimbursed? ◯ Yes ◯ No ◯ I'm not sure If yes, please describe the limitations or restrictions (for example, "no dental" "or no insurance premiums"):	
Have you been provided with any information about how much money is available to you for reimbursements? ◯ Yes ◯ No ◯ I'm not sure If yes, please describe when and how you were provided this information:	
Have you used the program (i.e. have you sought reimbursement for any health care expenses you incurred)? ◯ Yes ◯ No ◯ I'm not sure If yes, please describe any problems you encountered in submitting your claim or receiving your reimbursement payment (for example, delays in payment or overly-complicated process):	

Other Employer Health Care Benefits

Has you employer paid for or provided *any other* health care benefits (that you have not mentioned above) during the past 3 years? ◯ Yes ◯ No ◯ I'm not sure If yes, please describe these benefits:

Retaliation / Confidentiality

Have you ever complained or asked your employer about your right to health care benefits or expenditures?

○ Yes ○ No ○ I'm not sure

If yes, please provide the date of your inquiry/complaint, the name and title of who you talked to, and their response:

Has your employer ever retaliated against you for raising your right to health care benefits or expenditures?

○ Yes ○ No ○ I'm not sure

If yes, please describe what happened:

Do you wish to keep this complaint anonymous (i.e. keep your name confidential from your employer)?

○ Yes, I want to keep this complaint confidential.

○ No, I want my employer to know I submitted this complaint.

○ It doesn't matter. I don't care if my employer knows that I submitted this complaint.

Other San Francisco Employment Laws

Have you missed work since February 5, 2007 because you were sick or had a medical appointment or because you were caring for a family member who was sick or had a medical appointment?

○ Yes ○ No ○ I'm not sure

If yes, were you paid for the time-off?

Yes No I'm not sure

Have you been paid less than the San Francisco minimum wage for work performed in the City of San Francisco during the past three years? (see www.sfgov.org/olse/mwo for minimum wage rates)

○ Yes ○ No ○ I'm not sure

I declare that the information above is true to the best of my knowledge and belief.

Print Your Name	
Your Signature	Date

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