United States Department of Education
Office for Civil Rights

DISCRIMINATION COMPLAINT FORM

You do not have to use this form to file a complaint with the U.S. Department of Education's Office for Civil Rights (OCR). You may send OCR a letter or e-mail instead of this form, but the letter or e-mail must include the information in items one through nine and item fourteen of this form. If you decide to use this form, please type or print all information and use additional pages if more space is needed. An on-line version of this form, which can be submitted electronically, can be found at: http://www.ed.gov/about/offices/list/ocr/complaintintro.html.

Before completing this form please read all information contained in the enclosed packet including: Information About OCR's Complaint Resolution Procedures, Notice of Uses of Personal Information and the Consent Form.

1. Name of person filing this complaint:

Last Name (b)(6) Privacy, (b)(7)(C) Enf. Privacy **First Name** (b)(6) Privacy **Middle Name:** (b)(6) Privacy

Address: (b)(6) Privacy

City: Arcadia **State:** CA **Zip Code:** 91007

Home Telephone: (b)(6) Privacy **Work Telephone:** (b)(6) Privacy

E-mail Address: (b)(6) Privacy

2. Name of person discriminated against (if **other** than person filing). If the person discriminated against is age 18 or older, we will need that person's signature on this complaint form and the consent/release form before we can proceed with this complaint. If the person is a minor, and you do not have the legal authority to file a complaint on the student's behalf, the signature of the child's parent or legal guardian is required.

Last Name:_____ **First Name:**_____ **Middle Name:**_____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

Home Telephone:_____ **Work Telephone:**_____

E-mail Address: _____

3. OCR investigates discrimination complaints against institutions and agencies which receive funds from the U.S. Department of Education and against public educational entities and libraries that are subject to the provisions of Title II of the Americans with Disabilities Act. Please identify the institution or agency that engaged in the alleged discrimination. If we cannot accept your complaint, we will attempt to refer it to the appropriate agency and will notify you of that fact.

Name of Institution: Methodist Hospital

Address: 300 W. Huntington Drive

City: Arcadia **State:** CA **Zip Code:** 91007

Department/School: Emergency Department

4. The regulations OCR enforces prohibit discrimination on the basis of race, color, national origin, sex, disability, age or retaliation. Please indicate the basis of your complaint:

☐ Discrimination **based on race (specify)**

☐ Discrimination **based on color (specify)**

☑ Discrimination **based on national origin (specify)**

January 25th, 2013 -had me take a urine sample and told me to wait in the waiting room with it and made excuses as to why they aren't giving me proper care that I need. They were very unprofessional and there actions were unnecessary.

☐ Discrimination **based on sex (specify)**

☑ Discrimination **based on disability (specify)**

Based on prior 5150 hold

☐ Discrimination **based on age (specify)**

☑ **Retaliation because you filed a complaint or asserted your rights (specify)**

Regarding an incident that happened on October 7th, 2011 that I was admitted to the Emergency Room and placed on a 5150 hold that has affected this time attempting to get health treatment.

☐ **Violation of the Boy Scouts of America Equal Access Act (specify)**

5. Please describe each alleged discriminatory act. For each action, please include the date(s) the discriminatory act occurred, the name(s) of each person(s) involved and, why you believe the discrimination was because of race, disability, age, sex, etc. Also please provide the names of any person(s) who was present and witnessed the act(s) of discrimination.

October 7th, 2011 Methodist Emergency Room- Medical Records states specific details that are actually false. Accused of prior mental problems from another facility when I was an adolescent and was getting treatment and rehabilitation at Las Encinas Hospital.

January 25th, 2013- Methodist Emergency Room- After being treated unfair by the staff in the Emergency Room I was followed

6. What is the most **recent date** you were discriminated against?

Date: January 25th, 2013

7. If this date is **more than 180 days ago,** you may request a waiver of the filing requirement.

☑ I am requesting a waiver of the 180-day time frame for filing this complaint. Please explain why you waited until now to file your complaint.

Due to incarceration and family concerns and related problems that require the discovery process and not being able to get any legal counseling or representation.

8. Have you attempted to resolve these allegations with the institution through an internal grievance procedure, appeal or due process hearing?

◉ **YES** ○ **NO**

If you answered **yes,** please describe the allegations in your grievance or hearing, identify the date you filed it, and tell us the status. If possible, please provide us with a copy of your grievance or appeal or due process request and, if completed, the decision in the matter.

Arrested on Novemeber 2nd, 2011-Terrorist Threats charged with. Denied appeal and had mislead information that was in an entirely different department of the courthouse than the department where I should have been in.

9. If the allegations contained in this complaint have been filed with any other Federal, state or local civil rights agency, or any Federal or state court, please give details and dates. We will determine whether it is appropriate to investigate your complaint based upon the specific allegations of your complaint and the actions taken by the other agency or court.

Agency or Court: Pasadena Superior Courthouse

Date Filed: October 2011

Case Number or Reference: 1) (b)(6) Privacy

Results of Investigation/Findings by Agency or Court:

Was not allowed to bring it to a civil department without an attorney. Was charged with Terrorist Threats.

10. If we cannot reach you at your home or work, we would like to have the name and telephone number of another person (relative or friend) who knows where and when we can reach you. This information **is not required,** but it will be helpful to us.

Last Name: (b)(6) Privacy **First Name:** (b)(6) Privacy **Middle Name** (b)(6) Privacy

Home Telephone (b)(6) Privacy **Work Telephone:** (b)(6) Privacy

11. What would you like the institution to do as a result of your complaint — what remedy are you seeking?

Information as to Medical Records from my father being released from USC Medical Center on October 7th, 2011. Legal Counseling regarding family law, probate law, personal injury and a copy of the police report filed that the police department will not give me without an attorney

12. We cannot accept your complaint if it has not been signed. Please sign and date your complaint below.

2/3/2013 (b)(6) Privacy
(Date) (Signature)

(Date) (Signature of person in Item 2)

Please mail the completed and signed Discrimination Complaint Form, your signed consent form and copies of any written material or other documents you believe will help OCR understand your complaint to the OCR Enforcement Office responsible for the state where the institution or entity about which you are complaining is located. You can locate the mailing information for the correct enforcement office on OCR's website at http://wdcrobcolp01.ed.gov/CFAPPS/OCR/contactus.cfm.

CONSENT FORM- FOR USE OF PERSONAL INFORMATION

Complainant's Name (print or type): (b)(6) Privacy [redacted]

Institution Against Which Complaint is Filed: Methodist Hospital

Please sign and date section A, section B or section C and return to the address below:

I have read the section, "Investigatory Uses of Personal Information" in the OCR document "Information about OCR's Complaint Processing Procedures," which explains OCR's use of personal information. I understand that the Privacy Act of 1974, 5 U.S.C. § 552a, and the Freedom of Information Act (FOIA), 5 U.S.C. § 552, govern the use of personal information submitted to all Federal agencies and their individual components, including OCR. I will cooperate with OCR's investigation and complaint resolution activities undertaken on my behalf. I understand that my failure to cooperate with OCR's investigation may result in the closure of my complaint.

A. **I give OCR my consent to reveal my identity (and/or that of my minor child/ward on whose behalf the complaint is filed) to the institution alleged to have discriminated, as well as other persons and entities, if OCR, in the course of its investigation or for enforcement activities, finds it necessary to do so.**

(b)(6) Privacy [redacted]
Signature

2/3/2013
Date

OR

B. **I do not give OCR my consent to reveal my identity (and/or that of my minor child/ward on whose behalf the complaint is filed).** I understand that OCR may have to close this complaint if OCR is unable to proceed with an investigation without releasing my identity (and/or that of my minor child/ward on whose behalf the complaint is filed).

Signature **Date**

C. **Alternatively, if you are not filing this complaint on your own behalf or on behalf of your own minor child/ward, you are responsible for obtaining written consent from the person on whose behalf the complaint is filed or, if he or she is a minor, that person's parent/guardian.**

I have read this document, and I agree with the person who filed this complaint. I wish you to proceed with OCR's investigation and resolution process. I give my consent for OCR to reveal my identity **(and/or that of my minor child/ward on whose behalf the complaint is filed)** to other persons to the extent necessary for the purpose of resolution or investigation of this complaint.

Name (print or type): (b)(6) Privacy [redacted]

Signature **Date**

[redacted]

Appellate Courts Case Information

CALIFORNIA COURTS
THE JUDICIAL BRANCH OF CALIFORNIA

2nd Appellate District

Change court

Court data last updated: 06/24/2012 09:05 AM

Docket (Register of Actions)

(b)(6) Privacy [redacted]

Date	Description	Notes
02/09/2012	Notice of appeal lodged/received (criminal).	(b)(6) Privacy [redacted]
02/09/2012	N/A sent to CAP for appointment recommendation.	
02/17/2012	Order filed.	Re appealability to CAP
02/24/2012	Record on appeal filed.	C-1 (44 pgs) R-1 (11 pgs) & PR
03/06/2012	Mail returned and re-sent.	aplt
03/20/2012	N/A sent to CAP for appointment recommendation.	
04/03/2012	Letter sent to:	CAP re no further informantion re appealability.
04/11/2012	Dismissal order filed.	
06/20/2012	Remittitur issued.	
06/20/2012	Case complete.	

Click here to request automatic e-mail notifications about this case.

[redacted]

Appellate Courts Case Information

CALIFORNIA COURTS
THE JUDICIAL BRANCH OF CALIFORNIA

2nd Appellate District

Change court

Court data last updated: 06/24/2012 09:05 AM

Parties and Attorneys

(b)(6) Privacy [redacted]

Party	Attorney
(b)(6) Privacy [redacted]	Office of the Attorney General 300 South Spring Street Los Angeles, CA 90013
	California Appellate Project 520 S. Grand Avenue 4th Floor Los Angeles, CA 90071

Click here to request automatic e-mail notifications about this case.

METHODIST HOSPITAL
300 West Huntington Drive, Arcadia, CA 91007

DTABITRAT

PATIENT ID (b)(6) Privacy (b)(6) Privacy (b)(6) Privacy

ARBITRATION AGREEMENT

It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Such arbitration shall be in accordance with the current Medical Arbitration Rules of the California Medical Association and the California Healthcare Association. This arbitration agreement shall apply to any legal claim or civil action in connection with this hospitalization or outpatient service, against the hospital or its employees and any doctor of medicine who has agreed, at this time or hereafter, as evidenced by a written agreement in the physician's medical staff file, to be bound by this provision, unless patient or undersigned initials below or unless rescinded by written notice within 30 days of signature. An agreement to arbitrate shall not be a precondition to the furnishing of services under this agreement.

If a patient or undersigned does **NOT** agree to arbitration then he/she will initial here: ____

This Hospital Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

Date: 10-07-2011 Time: 11:36 AM/PM

Signature: Received to Sign
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship: _____

Hospital: (b)(6) Privacy

Signature: [redacted]

8561-097 (1/08) (b)(6) Privacy

METHODIST HOSPITAL
300 West Huntington Drive, Arcadia, CA 91007

DTCONDADMI

PATIENT ID (b)(6) Privacy

CONDITIONS OF ADMISSION/SERVICE

8. PERSONAL BELONGINGS

I understand that I am encouraged to leave personal property at home. The Hospital has informed me that a fireproof safe is available where I may place small items of value. I understand that by law, the Hospital may not be liable at all for the loss or damage to money, jewelry, documents, or other personal items of unusual value that I choose not to place in the Hospital safe. Hospital liability for items placed in the fireproof safe is limited by law to $500.00 unless a receipt for a greater amount has been provided by the Hospital. The Hospital may assume liability for items I choose to keep with me and not place in the Hospital safe but only if negligence or willful wrongdoing by staff can be shown and only upon presentation of reasonable proof of the worth of the missing item(s). In most cases the hospital's liability is limited to $500.00. Civil Code Sec 1859.

☒ Decline ☐ Unable to initial Notice and understanding acknowledged: Initial _____

9. DANGEROUS BEHAVIOR

I understand that if I engage in behavior on Hospital premises that Hospital staff determine are dangerous to me or to others, I and/or my belongings may be searched without my consent and any illegal or dangerous drugs, weapons or other suspicious items my be seized and held in a secure location or turned over to the police for safekeeping until my discharge. I further understand that such behavior may cause staff to notify police who may chose to take action at their discretion.

☒ Decline ☐ Unable to initial Notice and understanding acknowledged: Initial _____

10. ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to the hospital of all insurance benefits payable for this hospitalization or for these outpatient services. I agree that the insurance company's payment to the hospital pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for the charges not paid according to this assignment.

☒ Decline ☐ Unable to initial Notice and understanding acknowledged: Initial _____

11. FINANCIAL AGREEMENT

I agree to promptly pay all hospital bills in accordance with the regular rates and terms of the hospital, including its charity care and discount payment policies, if applicable. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physicians, anesthesiologists, and others, will bill separately for their services. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

☒ Decline ☐ Unable to initial Notice and understanding acknowledged: Initial _____

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf. ☒ Decline ☐ Unable to initial

Date: 10/8/11 Time: 330 AM/PM

Signature: pt declined to sign
(Patient/Parent/Conservator/Guardian)

If signed by (b)(6) Privacy :

Witness: _____

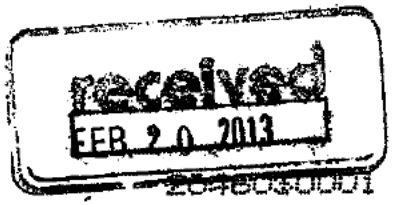
8561-046 (10/10) Page 1 of (b)(6) Privacy

Printed by MIRNA ARROYO
Job 23609 (07/18/2012 11:21) - Page 2

[redacted]

(b)(6) Privacy

FCL 1004691



EPA/ORC/OEJ

EPA - Office of Civil Rights
Office of Environmental Justice
Protection Agency
Mail Code: ~~2201A~~ 1201A
1200 Pennsylvania Ave, NW
Washington D.C. 20460-0001
Region 9