Title VI Complaint Form

Note: The following information is needed to assist in processing your complaint.

Complainant's Information:

Name _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

Person Discriminated Against (someone other than complainant) Name:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

Which of the following best describes the reason you believe the discrimination took place?

Race/Color (Specify) _____ National Origin (Specify) _____

On what date(s) did the alleged discrimination take place? _____

Describe the alleged discrimination. Explain what happened and who you believe was responsible (if additional space is needed, add a sheet of paper).

_____

_____

_____

_____

List names and contact information of persons who may have knowledge of the alleged discrimination.

_____

_____

Have you filed this complaint with any other federal, state, or local agency, or with any federal or state court? Check all that apply.

Federal Agency Federal Court State Agency State Court Local Agency

Please provide information about a contact person at the agency/court where the complaint was filed.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

Please sign below. You may attach any written materials or other information you think is relevant to your complaint.

Complainant Signature

Date

Submit form and any additional information to:

Hacienda HealthCare Title VI Program

Jim Hopper

Title VI Program Coordinator

1402 E South Mountain Avenue

Phone: (602) 243-4231 ext. 668

JHopper@haciendainc.org