HACIENDA HEALTHCARE

Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 Discrimination Complaint Form

Instructions: If you believe Hacienda HealthCare has engaged in discrimination against one or more persons based on medical condition or disability, please fill out this form completely, sign, and return to the address on the next page.

Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint will be made available for persons with disabilities upon request. Call (602) 243-4231 x104 for assistance.

Name of Complainant: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Person Discriminated Against:
(if other than the complainant) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

What date did the discrimination occur? _____

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use additional space on the next page if necessary):

Has a complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court? Yes ☐ No ☐

If yes, Agency or Court: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Date Filed: _____

Additional space for answers:

Signature: _____ Date: _____

Please Return Form by Certified Mail to:

Director of Human Resources/Designee
Hacienda HealthCare
1402 E. South Mountain Ave.
Phoenix, AZ 85042

Or by email at: Compliance@haciendahealthcare.org

Phone: (602) 243-4231 X104