OZARK CENTER
An Affiliate of Freeman Health System

TITLE VI/ADA DISCRIMINATION COMPLAINT FORM

"No person in the United States shall, on the basis of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

If you feel that you have been discriminated against in the provision of transportation services, please provide the following information to assist us in processing your complaint. Should you require any assistance in completing this form or need information in alternate formats, please let us know.

Please mail or return this form to:
Director of Risk/Quality Improvement
C/O Ozark Center, P.O. Box 2526, Joplin, MO 64803
pecahalan@freemanhealth.com or fax to 417-347-7608

PLEASE PRINT

1. Complainant's Name:
a. Address:
b. City: State: Zip Code:
c. Telephone (include area code): Home ( ) or Cell ( ) Work ( ) - ( ) -
d. Electronic mail (e-mail) address:
Do you prefer to be contacted by this e-mail address? ( ) YES ( ) NO
2. Do you need this form in a different format? ( ) YES specify:_____ ( ) NO
3. Are you filing this complaint on your own behalf? ( ) YES If YES, please go to question 7. ( ) NO If no, please go to question 4
4. If you answered NO to question 3 above, please provide your name and address. a. Name of Person Filing Complaint:
b. Address:
c. City: State: Zipcode:
d. Telephone (include area code): Home ( ) or Cell ( ) Work ( ) - ( ) -
e. Electronic mail (e-mail) address:
Do you prefer to be contacted by this e-mail address? ( ) YES ( ) NO
5. What is your relationship to the person for whom you are filing the complaint?
6. Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party. ( ) YES, I have permission. ( ) NO, I do not have permission.
7. I believe that the discrimination I experienced was based on (check all that apply): ( ) Race ( ) Color ( ) National Origin (classes protected by Title VI) ( ) Disability (class protected by ADA) ( ) Other (please specify)

Continued

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8. Date of Alleged Discrimination (Month, Day, Year):
9. Where did the Alleged Discrimination take place?
10. Explain as clearly as possible what happened and why you believe that you were discriminated against. Describe all of the persons that were involved. Include the name and contact information of the person(s) who discriminated against you (if known). *Use the back of this form or separate pages if additional space is required.*
11. Please list any and all witnesses' names and phone numbers/contact information. *Use the back of this form or separate pages if additional space is required.*
12. What type of corrective action would you like to see taken?
13. Have you filed a complaint with any other Federal, State, or local agency, or with any Federal or State court? ( ) YES If yes, check all that apply. ( ) NO a. ( ) Federal Agency (List agency's name) b. ( ) Federal Court (Please provide location) c. ( ) State Court d. ( ) State Agency (Specify Agency) e. ( ) County Court (Specify Court and County) f. ( ) Local Agency (Specify Agency)
14. If YES to question 14 above, please provide information about a contact person at the agency/court where the complaint was filed. Name: Title:
Agency: Telephone: ( ) -
Address:
City: State: Zip Code:

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

Signature and date is required:

_____ _____
Signature Date

If you completed Questions 4, 5 and 6, your signature and date is required:

_____ _____
Signature Date

If information is needed in another language, contact the Director of Risk and Quality Improvement at 417-347-7600, or at pecahalan@freemanhealth.com.

Si necesita información en otro idioma, comuníquese con el Director de Riesgos y Mejora de la Calidad al 417-347-7600 o al pecahalan@freemanhealth.com.

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