WestCare GUIDANCE CARE CENTER – MARATHON, FL

Title VI Complaint Form

Section I:				
Name:				
Address:				
Telephone (Home):			**Telephone (Work):**	
Electronic Mail Address:				
Accessible Format Requirements?	Large Print		**Audio Tape**	
	TDD		**Other**	
Section II:				
Are you filing this complaint on your own behalf?		Yes*	No	
*If you answered "yes" to this question, go to Section III.				
If not, please supply the name and relationship of the person for whom you are complaining:				
Please explain why you have filed for a third party: _____				
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.		Yes	No	
Section III:				
I believe the discrimination I experienced was based on (check all that apply):				
[ ] Race	[ ] Color	[ ] National Origin	[ ] Age	
[ ] Disability	[ ] Family or Religious Status	[ ]	Other	(explain) _____
Date of Alleged Discrimination (Month, Day, Year): _____				
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please use the back of this form.				
_____				
_____				
Section IV				
Have you previously filed a Title VI complaint with this agency?		Yes	No	

Section V
Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court? [ ] Yes [ ] No If yes, 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:
Title:
Agency:
Address:
Telephone:
Section VI
Name of agency complaint is against:
Contact person:
Title:
Telephone number:

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

Signature and date required below

_____ _____

Signature Date

Please submit this form in person at the address below, or mail this form to:

Mr. Bob Neri
Senior Vice President / Chief Clinical Officer (CCO)
PO Box 12019
St. Petersburg, FL 33733-2019

Email: Robert.neri@westcare.com