

# WestCare Gulf Coast Florida, Inc.

## Title VI Complaint Form

<b>Section I:</b>					
<b>Name:</b>					
<b>Address:</b>					
<b>Telephone (Home):</b>			<b>Telephone (Work):</b>		
Electronic Mail Address:					
Accessible Requirements?	Format	Large Print		<b>Audio Tape</b>	
		TDD		<b>Other</b>	
<b>Section II:</b>					
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	
<b>Section III:</b>					
I believe the discrimination I experienced was based on (check all that apply):					
<input type="checkbox"/> Race	<input type="checkbox"/> Color	<input type="checkbox"/> National Origin	<input type="checkbox"/> Age		
<input type="checkbox"/> Disability	<input type="checkbox"/> Family or Religious Status	<input type="checkbox"/>	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.					
_____					
_____					
<b>Section IV</b>					
Have you previously filed a Title VI complaint with this agency?			Yes	No	

<b>Section V</b>
Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply: <input type="checkbox"/> Federal Agency: _____ <input type="checkbox"/> Federal Court _____ <input type="checkbox"/> State Agency _____ <input type="checkbox"/> State Court _____ <input type="checkbox"/> Local Agency _____
Please provide information about a contact person at the agency/court where the complaint was filed.
<b>Name:</b>
<b>Title:</b>
<b>Agency:</b>
<b>Address:</b>
<b>Telephone:</b>
<b>Section VI</b>
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

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Larry McArthur, VP of Operations, WestCare Gulfcoast Florida, Inc.

1735 Dr. Martin Luther King, Jr. St. S.

St. Petersburg, FL 33705

Mailing Address:

PO Box 12019

St. Petersburg FL 33733-2019

PH 727-490-6767 FX 727-825-0573