

Title VI Complaint Form



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|---|--------|--------------------------------|---|--|----|
| Section I: | | | | | |
| Name: | | | | | |
| Address: | | | | | |
| Telephone (Home): | | | Telephone (Work): | | |
| Email Address: | | | | | |
| Accessible Requirements? | Format | 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): | | | | | |
| <input type="checkbox"/> Race | | <input type="checkbox"/> Color | | <input type="checkbox"/> National Origin | |
| 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? | | | | | |
| <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 _____ | | |

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|--|
| 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

If information is needed in another language, contact 833.289.0227.

Please submit this form to:

Catholic Social Services of the Miami Valley
100 S Main Avenue, Suite 101
Sidney, Ohio 45365

833.289.0227
rideconnect@cssmv-sidney.org