

Ozarks Medical Center – Behavioral Healthcare
TITLE VI/ADA COMPLAINT FORM

Title VI of the Civil Rights Act of 1964 states “No person in the United States shall, on the ground of race, color, or notational origin, be excluded from participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” Title
42 U.S.C. Section 2000d

Please provide the following information necessary in order to process your complaint. A formal complaint must be filed within 180 days of the occurrence of the alleged discriminatory act. Assistance is available upon request:

Complete this form and return to:

Ozarks Medical Center - Behavioral Healthcare, PO Box 1100, West Plains, MO 65775

Complainant’s Name: _____	
Address: _____	City: _____
State: _____	Zip Code: _____
Telephone (Home): _____	(Work): _____
Person(s) discriminated against (if other than complainant)	
Name: _____	
Address: _____	City: _____
State: _____	Zip Code: _____
Telephone (Home): _____	(Work): _____
What is the discrimination based on? <input type="checkbox"/> Race/Color <input type="checkbox"/> National Origin <input type="checkbox"/> Sex <input type="checkbox"/> Disability <input type="checkbox"/> Low Income <input type="checkbox"/> Limited English Proficiency	
Date of the alleged discrimination: _____	Location: _____
Agency or person who was responsible for alleged discrimination: _____	

Please sign and date. The complaint will not be accepted if it has not been signed. You may attach

Describe the alleged discrimination. Explain what happened and who you believe was responsible: _____

List names and contact information of persons who may have knowledge of the alleged discrimination: _____

How can this complaint be resolved? How can the problem be corrected? _____

any written materials or other supporting information that you think is relevant to your complaint.

Signature

Date