

# Discrimination ADA/Title VI Complaint Form

<b>Section I:</b>		
Name:		
Address:		
Telephone (Home):	Telephone (Work):	
Electronic Mail Address:		
Accessible Format Requirements?	<input type="checkbox"/> Large Print	<input type="checkbox"/> Audio Tape
	<input type="checkbox"/> TDD	<input type="checkbox"/> Other
<b>Section II:</b>		
Are you filing this complaint on your own behalf?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
<i>*If you answered "yes" to this question, go to <b>Section III</b>.</i>		
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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section III:</b>		

I believe the discrimination I experienced was based on (check all that apply):

- Race       Color       National Origin       Disability

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 VI:**

Have you previously filed a Discrimination Complaint with this agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please provide any reference information regarding your previous complaint.

\_\_\_\_\_  
\_\_\_\_\_

**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:

<b>Section VI:</b>
Name of agency complaint is against:
Name of person complaint is against:
Title:
Location:
Telephone Number (if available):

You may attach any written materials or other information that you think is relevant to your complaint.  
 Your signature and date are **required** below:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

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

**West Yavapai Guidance Clinic dba Polara Health**  
**Diane Onofrio, Director of Quality Management & Title VI Coordinator**  
**3343 N. Windsong Drive, Prescott Valley, AZ 86314**  
**928-445-5211 x3669**  
**d.onofrio@PolaraHealth .com**

A copy of this form can be found online at **www.Polara Health.com**

If information is needed in another language, contact **928-445-5211 x1**. \*Para información en Español llame: **Diane Onofrio, 928-445-5211 x3669**