

# Aspire Health Partners, Inc.

## Title VI Complaint Form

<b>Section I:</b>			
Name:			
Address:			
Telephone (Home):		Telephone (Work):	
Electronic Mail Address:			
Accessible Format Requirements?	Large Print		Audio Tape
	TDD		Other
<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

