Discrimination ADA/Title VI Complaint Form

Section I:		
Name:		
Address:		
Telephone (Home):	Telephone (Work):	
Electronic Mail Address:		
Accessible Format Requirements?	☐ 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):

☐ 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?	☐ Yes	☐ No

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:
Section VI:
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:

Hopi Tribe Medical Transportation Program - DHHS
Carrie Dewangyumptewa, Medical Transportation Supervisor
P.O. Box 123, Kykotsmovi, Arizona 86039
(928) 737-6341
CDewangyumptewa@hopi.nsn.us

A copy of this form can be found online at **https://www.hopi-nsn.gov.** If information is needed in another language, contact **(928) 737-6341**. Uma hopiikwawat it nanaptanit, peq wangwayani: (928) 737-6341. *Para información en Español llame: **Carrie Dewangyumptewa, (928) 737-6341.**