UNITED COMMUNITY HEALTH CENTER
Serving Southern Arizona Since 1983

TITLE VI COMPLAINT FORM

Any person who believes that he or she has been discriminated against, and believes the discrimination was based upon race, color or national origin may file a formal complaint

Please provide the following information to process your complaint.

Section I:

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Preferred Phone number: _____ Alternate Number: _____

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 you answered "no" to this question, please supply the name and relationship of the person for whom you are complaining: _____

If you are filing on behalf of a third party, please explain why: _____

_____

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:

Have you filed this complaint with the Federal Highway Administration (FHWA) or the ADOT Civil Rights Office? Yes ◯ No ◯

If yes, please provide information about a contact person at the agency where the complaint was filed.

Name: _____

Title: _____

Agency: _____

Address: _____

Telephone: _____

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

Race ☐ Color ☐ 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:

Signature and date required below:

_____ _____
Signature Date

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

United Community Health Center - Maria Auxiliadora, Inc.
Chief Medical Officer
1260 S Campbell Rd #2
Green Valley, AZ 85614
520-407-5600