ADULT DAY SERVICES
AT UNION HOSPITAL
301 Augustine Herman Hwy., Suite B, Elkton, MD 21921
Phone 410-392-0539 Fax 410-398-1838

Civil Rights Act Complaint Form

Section I:

Name:	
Address:	
Phone(home):	Phone(cell):
Email address:	
Accessible form requirements: ☐ Large print ☐ Audio tape	

Section II:

Are you filing this complaint on your own behalf? ☐ Yes ☐ No If you answered yes to this question, please proceed to **Section III** If you answered no to this question, please complete the following:
Name of person for whom you are filing:
Relationship to person for whom you are filing:
Please explain why the person for whom you are filing is unable to file on own:
Please confirm that you have obtained permission from the aggrieved party if you are filing on behalf of someone else. ☐ Yes ☐ No

Section III:

I believe the discrimination I experienced was based on (check all that applies): ☐ Race ☐ Color ☐ National Origin ☐ Sex ☐ Age ☐ Disability ☐ Language Access
Date of the discrimination (month, day, year):
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all person(s) 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 IV

Have you previously filed a Title VI or Civil Rights Act complaint with this agency? ☐ Yes ☐ No

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 ☐ State Agency ☐ Local Agency

☐ Federal Court ☐ State Court

Please fill out the contact information below for the agency/court where the complaint was filed.

Name:

Title:

Agency:

Address:

Telephone:

Section VI

Name of agency complaint is against:
Contact person and title:
Telephone:

You may attach any written material or other information that you think is relevant to your complaint. Signature and date required below.

_____ _____

Signature **Date**

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

Adult Day Services at Union Hospital
301 Augustine Herman Hwy., Ste. B
Elkton, MD 21921