St. Vincent’s Special Needs Services
TITLE VI DISCRIMINATION COMPLAINT FORM

Name: ________________________________________________________________________________

Street Address: ________________________________________________________________________

City/State/Zip: _________________________________________________________________________

Phone: _____________________________________ Email: ____________________________________

Discrimination because of:
__Race/__Color/__National Origin/__Sex/__Age/__Disability/__Other

Are you filing this complaint on your own behalf?   ___Yes   ___No*

*If you answered “no” 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 you have obtained permission of the aggrieved party to file on their behalf:
___Yes   ___No

Please provide the date(s) and location of the alleged discrimination:
____________________________________________________________________________________

Please provide the name(s) of the individual(s) who allegedly discriminated against you including
their contact information (if known).
__________________________________________________________________________________

__________________________________________________________________________________

Please provide the names, addresses and telephone numbers of any witnesses:
__________________________________________________________________________________

__________________________________________________________________________________
Briefly explain what happened, how you were discriminated against and who was involved. Please include how other persons were treated differently from you. Use extra sheets if needed:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you previously filed a Title VI complaint with this agency:  ___Yes   ___No

Have you filed this complaint with any of the following:

___Federal Agency/ ___Federal Court/ ___State Court/ ___State Agency/ ___Local Agency

Name of Agency or Court: ____________________________________________________
Contact Name and Title: _____________________________________________________
Address: __________________________________________________________________
Phone: __________________________Email: _____________________________________

Name of agency complaint is against:

Name of Agency: ____________________________________________________________
Contact Name and Title: _____________________________________________________
Phone: __________________________Email: _____________________________________

Signature:  ________________________________________________________________  Date:  __________________________

Please include any written materials pertaining to your complaint.

It is your right to submit the form to any or all of the following:

Director of Adult Services  CT Dept. of Transportation  Federal Transportation Agency
St. Vincent’s Special Needs Svcs  2800 Berlin Turnpike  Office of Civil Rights
975 Oronoque Lane  P. O. Box 317546  East Building, 5th Floor – TCR
Stratford, CT 06614  Newington, CT 06131  1200 New Jersey Avenue, SE
Stratford, CT 06614  Newington, CT 06131  Washington, DC 20590

St. Vincent’s Special Needs Services will notify CTDOT of any Title VI complaints filed against the organization within 10 business days of receipt.