Hope Clinic for Women
Title VI Complaint Form

Complaints must be filed within 180 days of the alleged act of discrimination.

1. What is the name of the person discriminated against?

   Name ____

   Address ____

   City, State, and Zip Code ____

   Telephone *(Home)* (_______) ____________________ *(Business)* (___________) _____________

2. What is the name and address of the institution, agency, or person that you believe discriminated against you?

   Name ____

   Address: ____

   City, State, and Zip Code ____

   Telephone Number (______) ____

3. What was the reason you believe you were discriminated against? Was it because of your:

   a. Race ❒ b. Color ❒

   c. National Origin ❒

4. When do you believe that the discrimination took place? ___________________________________

5. In your own words, explain what happened and who you believe was responsible. Please be as specific as possible. You may attach additional sheets if needed.

   ____

   ____

   ____

7. Are you filing this complaint for someone else? ☐ Yes ☐ No

If yes, against whom do you believe the discrimination was directed?

First Name ______________________________________ Last Name _____________________

8. 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 ☐

9. What is the name of the contact person at the agency/court where the complaint was filed?

Name ____

Agency/Court Name ____

Address ____

City, State, and Zip Code ____

Telephone Number (_______) ____

10. Please sign below. You may attach any written materials or other information that you think can be helpful to us in looking into your complaint.

____ ___________________________

Complainant's Signature Date

This form may be mailed to:

Sara Ellis
Hope Clinic for Women
1810 Hayes Street
Nashville, TN 37203