



Trinity Assistance Corporation

Providing innovative services to People with Developmental and Intellectual Disabilities since 2003

Appendix D: Title VI COMPLAINT FORM

Name _____

Address _____ City _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Basis of Complaint: (place checkmark)

Race

Color

Sex

National Origin

Age

Disability

Type of Complaint (place checkmark)

Program

Service

Benefit

Activity

Who allegedly discriminated against you?

Name _____

Address _____ City _____ Zip _____

Telephone _____

If an organization what is its name?

Name of Organization _____



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Address _____ City _____ Zip _____

Telephone _____

Name of Contact _____

How were you discriminated against?

Dates and times discrimination occurred?

Were there any other witnesses to the discrimination?

Name	Title	Work Phone	Home Phone
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Have you filed your complaint with anyone else?

Who _____

When _____

Do you have an Attorney in this matter?

Name _____

Address _____ City _____ Zip _____



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When did you acquire _____

Signed _____ Date _____

Mail to:

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