HI-DESERT MEDICAL CENTER
HI-DESERT MEMORIAL HEALTH CARE DISTRICT

Administrative Offices:
58375 29 Palms Highway, Ste. B
Yucca Valley, CA 92284
Phone (760) 365-9305
Fax (760) 365-9309

Hi-Desert Memorial Health Care District Title VI Complaint Form

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

Section I:			
Name:			
Address:			
Telephone (Home):		Telephone (Wk):	
E-Mail Address:			
Accessible Format Requirements? *(Check all that apply)*	☐ Large Print ☐ TDD ☐ Audio Tape ☐ Other:		

Section II:		
Are you filing this complaint on your own behalf?	☐ Yes*	☐ No
If you answered "yes", please skip to **Section III*		
If not, please supply the name and relationship of the person for whom you are filing this complaint:		
Please explain why you are filing for this person:		
Please confirm that you have obtained permission of the complaining person if you are filing on their behalf.	☐ Yes	☐ No

Section III:			
I believe the discrimination I 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 the names and contact information of any witnesses.			
(Additional space provided on reverse)			

Section III, Description of Discrimination, continued

Section IV:
Have you previously filed a Title VI complaint with this agency? ☐ Yes ☐ No
Section IV:
Have you filed a 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 ☐ Federal Court ☐ Local Agency ☐ State Court

You may attach any written materials or other information that you think is relevant to your complaint.

Please sign here: _____

Note: HDMHCD cannot accept your complaint without a signature.

Date: _____

Please mail your completed form to:

Hi-Desert Memorial Health Care District
Hi-Desert Family Health Clinics - Administrative Offices
ATTN: Executive Director
58375 29 Palms Highway, Suite B
Yucca Valley, CA 92284
Fax (760) 365-9309
Email: admin@hidesertclinics.org

If information is needed in another language, contact (760) 365-9305.

Si necesita información en otro idoma, llame al (760) 365-9305.