**Goochland Free Clinic and Family Services**
**Title IV (Non-Discrimination) Compliant Form**

**Section I**

Name:_____ Date of Complaint: _____

Address: _____

Home Phone: _____Other Phone: _____

Email: _____

Accessible Format Requirements (check all that apply)
_____Large Print _____Audio Tape _____ TDD _____Other

**Section II**

Are you filing this complaint on your own behalf? ___ yes* ___ no
*If yes, go to Section III

If, no, please share the name and relationship of the person for whom you are complaining:

Name: _____ Relationship: _____

Reason you are complaining on behalf of this person (why are they not completing the form themselves): _____

_____

Do you have the permission of the aggrieved party to file 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, Date, 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 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 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, circle all that apply.

Federal Agency Federal Court State Agency State Court Local Agency

Please provide information about a contact person at the agency/court where the complaint was filed.

| Name | Title | Agency | Address | Phone |
|---|---|---|---|---|
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**Section VI**

Name of Agency complaint is about: _____

Contact Person: _____ Title: _____

Phone Number: _____ Email: _____

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

_____

Signature (required) Date (required)

Submit this form in person or mail to the address below:

Goochland Free Clinic and Family Services
P.O. Box 116 (3001 River Road West)
Goochland, VA 23063