



Notifying the Public of Rights Under Title VI

Community Health of South Florida, Inc. (CHI)

- Community Health of South Florida (CHI) operates its programs and services without regard to race, color, and national origin in accordance with Title VI of the Civil Rights Act. Any person who believes she or he has been aggrieved by any unlawful discriminatory practice under Title VI may file a complaint with Community Health of South Florida (CHI).
- For more information on Community Health of South Florida (CHI)'s civil rights program, and the procedures to file a complaint, contact 305-253-5100, (TTY 711); email jdreyes@chisouthfl.org or visit our administrative office at 10300 SW 216 Street, Miami, Florida 33190. For more information, visit <https://www.chisouthfl.org/>.
 - If information is needed in another language, contact 305-253-5100



Community Health of South Florida (CHI)

Title VI Complaint Form

Section I:					
Name:					
Address:					
Telephone (Home):			Telephone (Work):		
Electronic Mail Address:					
Accessible Requirements?	Format	Large Print		Audio Tape	
		TDD		Other	
Section II:					
Are you filing this complaint on your own behalf?			Yes*	No	
*If you answered "yes" to this question, go to Section III.					
If not, 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 that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.			Yes	No	
Section III:					
I believe the discrimination I experienced was based on (check all that apply):					
<input type="checkbox"/> Race	<input type="checkbox"/> Color	<input type="checkbox"/> National Origin	<input type="checkbox"/> Age		
<input type="checkbox"/> Disability	<input type="checkbox"/> Family or Religious Status	<input type="checkbox"/>	Other	(explain)	

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 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, check all that apply:	
<input type="checkbox"/> Federal Agency: _____	
<input type="checkbox"/> Federal Court _____	<input type="checkbox"/> State Agency _____
<input type="checkbox"/> State Court _____	<input type="checkbox"/> Local Agency _____
Please provide information about a contact person at the agency/court where the complaint was filed.	
Name:	
Title:	
Agency:	
Address:	
Telephone:	
Section VI	
Name of agency complaint is against:	
Contact person:	
Title:	
Telephone number:	

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

Signature and date required below

Signature Date

Please submit this form in person at the address below, or mail this form to: Carolina Castillo,
 Community Health of South Florida (CHI) Title VI Liaison
 10300 SW 216 Street
 Miami, FL 33190

