



TITLE VI & ADA COMPLAINT FORM

Name of Complainant	Primary Phone
Home Address	Secondary Phone
Email	
Person discriminated against (if other than Complainant)	Primary Phone
Home Address	Secondary Phone

1. Specific basis of discrimination (circle all that apply):

RACE COLOR NATIONAL ORIGIN DISABILITY

2. Date of alleged discriminatory acts: _____

3. Respondent (Name, position and work location of person you believe discriminated against you, if applicable):

Name	
Position	Work Location



4. Describe how you believe you were discriminated against. What happened and who was responsible? If needed, attach additional sheets of paper.

5. Did you file this complaint with another federal, state or local agency; or with a federal or state court? YES NO

FEDERAL AGENCY FEDERAL COURT STATE AGENCY STATE COURT LOCAL AGENCY

Date Filed _____

6. Provide contact information or the agency or court where you also filed the complaint:

Name	Phone
Address	Email

Sign complaint in the space below. Attach any supporting documents.

I affirm that the information I have provided regarding this complaint is complete and accurate to the best of my knowledge.

Signature	Date
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Please complete and return to:
CICOA Aging & In-Home Solutions
ATTN: Director, Way2Go Transportation
 8440 Woodfield Crossing Blvd. Suite 175
 Indianapolis, IN 46240