

US HHS PROGRAMS ONLY

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

CIVIL RIGHTS COMPLAINT FORM

Title VI of the Civil Rights Act of 1964
Title IX of the Education Amendments of 1972
Section 504 Rehabilitation Act of 1973
Age Discrimination Act of 1975
Section 1557 of the Patient Protection and Affordable Care Act of 2010
Title II and Title II of the Americans with Disabilities Act (ADA) of 1990
Title II and Title III of the ADA Amendments Act of 2008

Please tell us if you need assistance completing this form because you do not speak English or have a disability. Free language assistance and/or other aids and services are available upon request. Please contact the Department’s Compliance Attorney, Julie Cronin, NC DHHS Interim Compliance Attorney, Office of the Secretary, 919-855-4800, julie.cronin@dhhs.nc.gov.

INSTRUCTIONS: Please fill out (PRINT) this form completely and mail to the address listed on page 2.

SECTION 1:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

If someone is filling out this form on your behalf, please indicate that person’s name, address, telephone number and email, below:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

SECTION 2: DETAILS OF COMPLAINT

a) DHHS DIVISION/PROGRAM INVOLVED: _____

b) DATE(S) OF ALLEGED VIOLATION(S): _____

c) I believe that I have been (or someone else has been) discriminate against on the basis of (check all that apply):

___ **Race**

___ **Color**

___ **National origin**

___ **Sex (including gender identity, sexual orientation, and pregnancy)**

___ **Disability**

___ **Age**

___ **Religion**

___ **Other (please list):**

d) DESCRIPTION OF ACTIONS YOU BELIEVE ARE PROHIBITED. (Please list names and addresses of individuals who were involved and who can be contacted to provide information relevant to this complaint. You may attach additional sheets as necessary. Please attach copies of any documents or evidence you would like DHHS to consider when investigating your request.)

e) Have efforts been made to resolve this complaint through other informal means?

___ yes ___ no.

If yes, please specify those means, and provide the status.

f) Have you filed a complaint on this alleged violation with any federal office of civil rights, other agency, or in a court?

_____ yes _____ no.

If yes, please specify the federal agency or court, any complaint or case number, and provide the status of that complaint.

g) Have you previously filed a complaint with regard to this alleged violation with any other state agency?

_____ yes _____ no.

If yes, please provide details and the status of that complaint.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____

Mail this form and any supporting information to:

ATTN: DHHS Compliance Attorney
Office of General Counsel
2001 Mail Service Center
Raleigh, NC 27699-2001

If you have a disability that renders a non-written form of communication necessary, the Department or Civil Rights Coordinator upon request shall make reasonable efforts to effectively communicate with you. For more information, please contact the Department's Interim Compliance Attorney, Julie Cronin, NC DHHS Interim Compliance Attorney, Office of the Secretary, 919-855-4800, julie.cronin@dhhs.nc.gov.

**You may also file a discrimination complaint directly with the
U.S. Department of Health and Human Services (US HHS).**

Below is the process to file directly with US HHS:

The U.S. Department of Health and Human Services (HHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

US HHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact HHS at 1-877-696-6775.

If you believe that HHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the [Office for Civil Rights Complaint Portal](#), or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

This institution is an equal opportunity provider.