Miami Cerebral Palsy Residential Services, Inc.

Environmental Services **Section VIII: Transportation**Effective Date: 4/30/19

POLICY NUMBER: T160c

SUBJECT: Title VI Complaint Form

AUTHORITY REFERENCE:

- 1.) Code of Federal Regulations, Transportation Title 49 (CFR 49)
- 2.) Florida Department of Transportation (FDOT)

Section I:								
Name:								
Address:								
Telephone (Home):	Telephone	Telephone (Work):						
Electronic Mail Addre	ess:							
	Format	Large Print		Audio Tape				
Requirements?		TDD		Other				
Section II:								
Are you filing this complaint on your own behalf?				Yes* No		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 th party if you are filing on behalf of a third party.				d Yes		No		
Section III:								
I believe the discrimination I experienced was based on (check all that apply):								
[] Race	[]C	olor	[] Nationa	[] National Origin [] Ag		Age		
[] Disability	[]F	amily or Religious Status]]	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	Yes	No					
Section V							
Have you filed this complaint with any other Federal,	State, or local agency	, or with any Feder	al or State court?				
[] Yes [] No							
If yes, check all that apply:							
[] Federal Agency:							
[] Federal Court	[] State Age	ncy					
[] State Court	[] 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 info	ormation that you t	hink is relevant to	your complaint.				
Signature and date required below							
Signature		Date					
Please submit this form in person at the address b	elow, or mail this fo	orm to:					
Patricia St Hubert.							
Miami Cerebral Palsy Residential Services, Inc.							
2200 NW 107 th Avenue							

Miami Florida 33172