CABARRUS HEALTH ALLIANCE
300 Mooresville Rd. Kannapolis, North Carolina 28081
Phone: 704-920-1000 • www.CabarrusHealth.org

Title VI Discrimination Complaint Form

Please note that an investigation may take up to 30 days to complete.

Full Name: _____ Phone number: _____

Address: _____

Date (s) you believe the discrimination occurred? _____

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible. (Attach additional pages as needed)

_____

_____

_____

_____

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE _____ DATE (mm/dd/yyyy) _____

If the person who has been discriminated against is a minor, please complete parent information below:

Name of parent/legal guardian signing form: _____

Parents/legal guardian signature: _____Date (mm/dd/yyyy) _____

The remaining information on this form is optional. Completing these following questions are voluntary and will not affect Cabarrus Health Alliance decision in the review of your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

____Braille ____ Large Print ____ Electronic mail ____ Sign language interpreter
____ TDD ____ foreign language interpreter (specify language):_____

____Other

If we cannot reach you directly, is there someone we can contact to help us reach you?

Contact's Name _____ Phone Number_____

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S) _____

Date Filed _____ Case Number (s) if known _____

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To submit your complaint with Cabarrus Health Alliance, please type or print, sign, and return completed complaint form to the Cabarrus Health Alliance at the address below:

Cabarrus Health Alliance

Melissa Blovsky

Compliance Officer

300 Mooresville Rd

Kannapolis, NC 28081

Contact Number (704)-920-1343

Fax: (704) 933-3329

TDD: (800) 537-7697

Email: melissa.blovsky@cabarrushealth.org

For office use below

Date complaint was received _____ Date reviewed: _____

Outcome of investigation: _____

Review completed by: _____