Christian Health Care Center (CHCC) Complaint Submission Form

Use this form for all complaints of discrimination, including NJ Transit Authority Title VI violations.

Submit this form to CHCC's Civil Rights Coordinator within 60 days of the date you became aware of the alleged discriminatory action, or within 180 days for a civil rights complaint specific to CHCC's Transportation Services.

Note: The following information is needed to assist in processing your complaint.

A. Complainant's information:

Name: _____

Address: _____

City/State/Zip Code:_____

Telephone number (home):_____

Email address: _____

B. Person discriminated against (if someone other than complainant):

Name: _____

Address: _____

City/State/Zip: _____

Telephone number (home):_____

Telephone number (work):_____

Email address: _____

CHCC:

- o Client
- o Resident
- o Patient
- o Consumer
- o Visitor
- o Other (please specify) _____

Relationship to the person for whom you are making a complaint: _____

Please explain why you have filed as 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.

- o Yes
- o No

C. Which of the following best describes the reason you believe the discrimination took place?

_____Race _____Color ____National origin _____Age _____Disability _____Sex

Other:_____
_____

D. On what date(s) did the alleged discrimination take place?

Date: _____

Date: _____

Date: _____

Date: _____

Date:_____

Other:_____
_____
_____

E. Please describe the alleged discrimination. Explain what happened and whom you believe was responsible. 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, and the remedy you are seeking. If additional space is needed, add a sheet of paper.

_____
_____
_____
_____
_____
_____

F. Have you filed this complaint with any other federal, state, or local agency, or with any federal or state court? List all that apply.

Federal agency_____

Federal court_____

State agency_____

State court_____

Local agency_____

If you have checked above, please provide information about a contact person at the agency/court where the complaint was filed.

Name: _____

Title: _____

Address: _____

City/State/Zip: _____

Telephone number (home): _____

Telephone number (work): _____

Email address: _____

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

Signature _____ Date _____

Attachments: Yes __ No __

H. Submit this form and any additional information to:

Christian Health Care Center

John Browne, Civil Rights Coordinator

301 Sicomac Ave., Wyckoff, NJ 07481