STATE OF TENNESSEE
DEPARTMENT OF HEALTH

Title VI of the Civil Rights Act of 1964

Discrimination Complaint Form

Federal law prohibits discrimination against persons based on their race, color or national origin. You have the right to complain to the Tennessee Department of Health if you feel that you have been discriminated against for these reasons. Please give us the following information so that we can look into your complaint. If you need help in completing this form, please let us know.

You may also file a complaint of discrimination if you believe you have been discriminated against when accessing TDH's Women, Infants, and Children (WIC) program; Farmers' Market Nutrition Program (FMNP), Senior Famers' Market Nutrition Program (SFMNP), or the Commodity Supplemental Food Program (CSFP). The USDA contact information is on the last page of this form.

1. What is the name of the person discriminated against?

   Name_____

   Address_____

   City, State, and Zip Code _____

   Telephone *(Home)* (____)_____*(Business)* (_____) _____

2. What is the name and address of the institution, agency, or person that you believe discriminated against you?

   Name_____

   Address:_____

   City, State, and Zip Code _____

   Telephone Number (____) _____

3. What was the reason you believe you were discriminated against? Was it because of your:

   a. Race ❒ b. Color ❒ c. National Origin ❒

4. When do you believe that the discrimination took place? _____

5. In your own words, explain what happened and who you believe was responsible. Please be as specific as possible. You may attach additional sheets if needed.

   _____

   _____

   _____

   _____

6. Have you tried to resolve this complaint with the institution, agency or person? ❒ Yes ❒ No

If yes, what is the status of the complaint?

_____

_____

7. Are you filing this complaint for someone else? ❒ Yes ❒ No

If yes, against whom do you believe the discrimination was directed?

First Name_____Last Name _____

8. Have you filed this complaint with any other federal, state, or local agency, or with any federal or state court? ❒ Yes ❒ No

If yes, check all that apply Federal agency ❒ Federal court ❒ State agency ❒

State court ❒ Local agency ❒

9. What is the name of the contact person at the agency/court where the complaint was filed?

Name_____

Agency/Court Name _____

Address_____

City, State, and Zip Code _____

Telephone Number (____) _____

10. Please sign below. You may attach any written materials or other information that you think can be helpful to us in looking into your complaint.

_____ _____

Complainant's Signature Date

Mail this form to:

Title VI Compliance Officer
Tennessee Department of Health
Andrew Johnson Bldg., 5th Floor
710 James Robertson Pkwy
Nashville, TN 37243
Phone: (615) 741-9421
Email: Luvenia.Harrison@tn.gov

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from Tennessee Department of Health to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You may also email or write a letter and send it to the address above.

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.