CALAVERAS COUNCIL of GOVERNMENTS

Calaveras Council of Governments
444 E. Saint Charles Street, Suite A
P.O. Box 280
San Andreas, CA 95249

Calaveras Council of Governments
Title VI Complaint Form

The Calaveras Council of Governments (CCOG) is committed to ensuring that no person is excluded from participation in or denied the benefits of its services on the basis of race, color or national origin, as provided by Title VI of the Civil rights Act of 1964, as amended. **Title VI complaints must be filed within 180 days from the date of the alleged discrimination.**

The following information is necessary to assist us in processing your complaint. If you require any assistance in completing this form, please contact (209) 754-2094. The completed form must be returned to Calaveras Council of Governments at: 444 E. Saint Charles Street, Suite A, P. O. Box 280, San Andreas, CA 95249.

Your Name:	Phone:	Alt. Phone:
Street Address:	City, State, Zip Code:	
Person(s) discriminated against (if someone other than complainant): Name(s):		
Street Address, City, State & Zip Code:		

Which of the following best describes the reason for the alleged discrimination that took place? (Circle one) Date of incident: _____

- Race
- Color
- National Origin

How were you discriminated against? Describe the nature of the action, decision, or conditions of the alleged discrimination. Explain as clearly as possible what happened and why you believe your protected status (basis) was a factor in the discrimination. Include how other persons were treated differently from you. (Attach additional page(s), if necessary).

_____

_____

_____

_____

Names of individuals (witnesses or others) whom we may contact for additional information to support or clarify your complaint:

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____

Have you filed a complaint with any other federal, state or local agencies? (Circle one)

Yes / No

If so, list agency/agencies and contact information below:

Agency:_____Contact Name: _____
Street Address, City, State & Zip Code: _____
_____
Phone: _____

Agency:_____Contact Name: _____
Street Address, City, State & Zip Code: _____
_____
Phone: _____

If you have an attorney representing you, please provide the following information:

Name:_____Firm Name: _____
Address:_____Telephone Number: _____
_____

I affirm that I have read the above charge and that it is true to the best of my knowledge, information and belief.

_____ _____
Complainant's Signature Date

_____
Print or Type Name

Date Received: _____

Received By: _____