Title VI Complaint Procedure

The following pertains only to Title VI complaints regarding the services of Cheyenne County Hospital's specialized transportation for elderly and disabled persons.

Title VI, 42 U.S.C. §2000d et seq., was enacted as part of the Civil Rights Act of 1964. At the heart of the regulation is the statement that:

> No person in the United States shall, on the ground of race, calm; or national origin, be excluded from participation in, be denied the benefits of or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Cheyenne County Hospital Specialized Transportation for Elderly and Disabled Persons program has in place a Title VI Complaint Procedure, which outlines a process for local disposition of Title VI complaints and is consistent with guidelines found in Chapter III of the Federal Transit Administration Circular 4702.lB, dated October 1, 2012.
http://www.fta.dot.gov/documents/FTA_Title_VI_FINAL.pdf

If you believe that Cheyenne County Hospital's specialized transportation for the elderly and disabled person's federally funded programs have discriminated your civil rights on the basis of race, color, or national origin you may file a written complaint by following the procedure outlined below:

1. Submission of Complaint.

Any person who feels that he or she, individually or as a member of any class of persons, on the basis of race, color, or national origin has been excluded from or denied the benefits of, or subjected to discrimination caused by the Cheyenne County Hospital Specialized Transportation for Elderly and Disabled Persons Program, may file a written complaint with the Cheyenne County Hospital Human Resources Director. A sample complaint form is available for download at www.cheyennecountyhospital.com and is available in hard copy at the Cheyenne County Hospital's Human Resources Director's office. Upon request, the director will mail the complaint form. **Such complaints must be filed within 180 calendar days after the date the discrimination occurred.**

Assistance in the preparation of any complaints will be provided to a person or persons upon request and as appropriate. **If information is needed in another language please contact the Human Resources Director at (785) 332-2104.**

Necitamos la informacion en otro lenguague, contacto (785) 332-2104.

Complaints should be mailed to or submitted by hand to:

Cheyenne County Hospital
Attn: Human Resources Director
210 W 1st Street
St. Francis, KS 67756

2. Referral to Review Officer
Upon receipt of the complaint, the Human Resources Director, will evaluate and investigate the complaint. If necessary, the Complainant shall meet with the Human Resources Director to further explain his or her complaint. The Human Resources Director shall complete his/her review no later than 45 calendar days after the date the agency received the complaint. If more time is required, the Human Resources Director shall notify the Complainant of the estimated time frame for completing the review. Upon completion of the review, the Human Resources Director shall make a recommendation regarding the merit of the complaint and whether remedial actions are available to provide redress. Additionally, the Human Resources Director may recommend improvements to the Cheyenne County Hospital Administrator relative to Title VI, as appropriate. The Human Resources Director will issue a written response to the Complainant in regard to his/her findings. This final report should include a summary of the investigation, all findings with recommendations, corrective measures where appropriate,

Upon receipt of a complaint, Cheyenne County Hospital's Human Resources Director shall forward a copy of this complaint and the resulting written response to the appropriate KDOT and FT A Region 7 contacts.

3. Request for Reconsideration
If the Complainant disagrees with the Human Resources Director's response, he or she may request reconsideration by submitting the request, in writing, to the Human Resources Director within 10 calendar days after receipt of the Human Resources Director's prior response. The request for reconsideration shall be sufficiently detailed to contain any items the Complainant fee ls were not fully understood by the Human Resources Director. The Human Resources Director will notify the Complainant of his or her decision in writing either to accept or reject the request for reconsideration within 10 calendar days. In cases where the Human Resources Director agrees to reconsider, the matter shall be reevaluated in accordance with Paragraph 2 above.

4. Appeal
If the request for reconsideration is denied, the Complainant may appeal the Human Resources Director's response by submitting a written appeal to the Cheyenne County Hospital Administrator no later than 10 calendar days after receipt of the Human Resources Director's written decision rejecting reconsideration. The Administrator will then make a determination to either request re-evaluation by the Human Resources Director or forward the complaint to KDOT for further investigation.

5. Submission of Complaint to the State of Kansas Department of Transportation
If the Complainant is dissatisfied with the Administrator's resolution of the complaint, he or she may also submit a written complaint within 180 days after the alleged date of discrimination to the State of Kansas Department of Transportation for further
investigation.

KDOT Office of Contract Compliance
Eisenhower State Office Building

700 Southwest Harrison
3rd Floor West
Topeka, KS 66603

Great Plains dba Cheyenne County Hospital (CCH)
Title VI / ADA Complementary Paratransit Complaint Form

The purpose of this form is to assist you in filing a complaint with the *(agency)*. You are not required to use this form; a letter containing the same information will be sufficient.

For questions about CCH's Americans with Disabilities Act (ADA) complaint procedures or complaint form contact Rance Ramsey, Hospital CEO, 785-332-2104 or rramsey@cheyennecountyhospital.com

Section I:				
Name:				
Address:				
Telephone (Home):			Telephone (Work):	
Electronic Mail Address:				
Accessible Format Requirements?	Large Print		Audio Tape	
	TDD		Other	
Section II:				
Are you filing this complaint on your own behalf?			Yes*	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 the aggrieved party if you are filing on behalf of a third party.			Yes	No
Section III:				

I believe the discrimination I experienced was based on (check all that apply):
[ ] Race [ ] Color [ ] National Origin [ ] Age
[ ] Disability [ ] Other (specify) ________________________

Date of Alleged Discrimination (Month, Day, Year): _______________

Time of Day: _______________

Location: _______________

(Continued on next page)
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 attach additional pages.

Witness(es): ☐ YES ☐ NO

List Witness(es): *(Attach a separate sheet, if necessary)*
(1) Name:
Phone Number: ( )
(2) Name:
Phone Number: ( )
(3) Name:
Phone Number: ( )
(4) Name:
Phone Number: ( )

(Continued on next page)

Section IV

Have you previously filed a Title VI complaint with this agency?	Yes	No

Section V
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 ________________
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 information that you think is relevant to your complaint.

Signature and date required below:

Signature ____ Date__________________________

Please submit this form in person at the address below, or mail this form to:

CCH, Attn: Rance Ramsey
210 W 1st Street
St. Francis, KS 67756

INTERNAL USE ONLY
To be completed by Title VI Compliance Officer
Accepted for formal Investigation ______/______/______

Referred to another department on ______/______/______
Rejected ______/______/______
Reason for Rejection:
____
____

____
Rance Ramsey, Hospital CEO and Title VI Compliance Officer

____
Date