



**VANTAGE HEALTH SYSTEM**  
**NORTHERN VALLEY ADULT DAY HEALTH CENTER**

**TITLE VI COMPLAINT FORM**

Title VI of the 1964 Civil Rights Act requires that “No person in the United States shall, on the grounds of race, color 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.”

NOTE: The following information is necessary to assist us in processing your complaint. Should you require any assistance in completing this form, please let us know.

For complaints concerning the Section 5310 (Senior and Persons with Disabilities) grant program funded by the Federal Transit Administration, complete and return this form to:

Director, Northern Valley Day Health Center  
c/o Vantage Health System  
Two Park Avenue  
Dumont, NJ 07628

1. Complainant's Name \_\_\_\_\_
2. Address: \_\_\_\_\_
3. City, State and Zip Code \_\_\_\_\_
4. Telephone Number (home) \_\_\_\_\_ (business) \_\_\_\_\_
5. Person discriminated against (if someone other than the complainant)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_



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

Was it because of your: (check reason)

- a. Race/Color \_\_\_\_\_ c. Age \_\_\_\_\_
b. National Origin \_\_\_\_\_ d. Disability \_\_\_\_\_

7. What date did the alleged discrimination take place and the location? Explain what happened and whom you believe was responsible. Please use the back of this form if additional space is required.

Blank lines for writing the answer to question 7.

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. Please provide information about a contact person at the agency where the complaint was filed.

Name: \_\_\_\_\_



Address: \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

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

\_\_\_\_\_  
Complainant's Signature

\_\_\_\_\_  
Date