Transportation Discrimination Complaint Form

If information is needed in another language, contact the Corporate Compliance Department, phone: 1-844-668-4100 or fax: 619-785-3372. DD/TTY: (800) 855-7100 for English to English, (800) 855-7200 for Spanish to Spanish. Patient Services Representatives at all locations are trained to assist any person with completing the complaint form.

Instructions: If you believe San Ysidro Health (SYHealth) has engaged in discrimination against one or more persons relating to its Mobile Health Services Transportation Operations Program (TOP), please fill out this form completely, in black ink or type-written form. Sign and return to the "Return To" address below. Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint, will be made available for persons with disabilities upon request to SANDAG.

Complainant: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Home: _____ Business: _____

Person Discriminated Against (if other than the complainant):

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Home: _____ Business: _____

When did the discrimination occur? (date): _____

I believe the discrimination I experienced or was made aware of was based on (check all that apply):

[ ] Race [ ] Color [ ] National Origin [ ] Disability [ ] Other

Describe the alleged acts of discrimination providing the name(s) where possible of the responsible individuals (use space on the next page or attach additional pages if necessary). If you marked "Other" above, include the category upon which you believe the discrimination was based (medical condition, sex, veteran status, etc.):

_____

_____

_____

_____

_____

Signature: _____

Date: _____

Return to:

Corporate Compliance Department
San Ysidro Health
1601 Precision Park Lane
San Diego, CA 92173
Phone: 1-844-668-4100; Fax: 619-785-3372
Email: teamcompliance@syhealth.org