

## **WESTFAIR RIDES, INC.**

### **KNOW THE RIGHTS THAT PROTECT US FROM DISCRIMINATION BASED ON RACE, COLOR OR NATIONAL ORIGIN**

#### **Forms of illegal discrimination**

WestFair Rides is a recipient of Federal financial assistance and complies with Title VI of the Civil Rights Act of 1964 and under Title 49 CFR Section 21.9(d). A recipient of Federal financial assistance may not, based on race, color or national origin:

- *Deny services, financial aid or other benefits provided as a part of health or human services programs.*
- *Provide a different service, financial aid or other benefit, or provide them in a different manner from those provided to others under the program.*
- *Segregate or separately treat individuals in any matter related to the receipt of any service, financial aid or other benefit.*
- *Fail to take reasonable steps to ensure meaningful access by limited English proficient (LEP) persons to the recipient's programs or activities.*

#### **How to file a complaint of discrimination with the Office for Civil Rights (OCR)**

If you believe that you or someone else has been discriminated against because of race, color or national origin by an entity receiving financial assistance from HHS, you or your legal representative may file a complaint with OCR. Complaints must be filed within 180 days from the date of the alleged discrimination. You may send a written complaint or you may complete and send OCR the Complaint Form available on the OCR webpage at [www.hhs.gov/ocr](http://www.hhs.gov/ocr). The complaint form is also available on the OCR webpage in a number of other languages under the Civil Rights Information in Other Languages section. The following information is required:

- *Your name, address and telephone number.*
- *You must sign your name on everything you write. If you file a complaint on someone's behalf — e.g. spouse, friend, client, etc. — include your name, address, telephone number, and statement of your relationship to that person.*
- *Name and address of the institution or agency you believe discriminated.*
- *When, how and why you believe discrimination occurred.*
- *Any other relevant information.*

If you mail the complaint, be sure to send it to the attention of the regional manager at the appropriate OCR regional office. OCR has ten regional offices and each regional office covers specific states. Complaints may also be mailed to OCR Headquarters at the following address:

**Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW.  
H.H.H. Building, Room 509-F Washington, D.C. 20201**

**To learn more: Visit OCR online at [www.hhs.gov/ocr](http://www.hhs.gov/ocr) or call OCR toll-free at 1-800-368-1019 or Email OCR at [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov) TDD: 1-800-537-7697.**

Language assistance services for OCR matters are available and provided free of charge. OCR services are accessible to persons with disabilities.

**New York State Department of Transportation  
Complaint of Discrimination Form**

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Basis of Complaint**

- Race
- Color
- Sex
- National Origin
- Age
- Disability

**Type of Complaint**

- Program  Service  Benefit  Activity

Who allegedly discriminated against you? Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

If an organization what is its name?

Name of Organization \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_  
Name of Contact \_\_\_\_\_

How were you discriminated against?

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Where did alleged discrimination occur?

\_\_\_\_\_  
\_\_\_\_\_

Date/s and times discrimination occurred?

First time \_\_\_\_\_ Second time \_\_\_\_\_ Third time \_\_\_\_\_

Were there any other witnesses to the discrimination?

Name	Title	Work Telephone	Home Telephone

What can the Department do to resolve the complaint?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you filed your complaint with anyone else?

Who \_\_\_\_\_ When \_\_\_\_\_  
Complaint number, if known \_\_\_\_\_

Do you have an Attorney in this matter?

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

When did you acquire \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Mail to: Title VI Coordinator  
Office of Civil Rights  
New York State Department of Transportation  
50 Wolf Road  
Albany, New York 12232 or FAX (518) 485-5517  
Phone (518) 457-1129 Email: OCR-Title VI @dot.state.ny.us