

**The Centers for Habilitation/TCH  
Americans with Disabilities Act and  
Section 504 of the Rehabilitation Act of 1973 Discrimination  
Complaint Form**

**Instructions:** If you believe TCH has engaged in discrimination against one or more persons based on medical condition or disability, please fill out this form completely, sign, and return to the address on the next page.

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. Call 480-730-4132 for assistance

Name of Complainant: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Person Discriminated Against:  
(if other than the complainant) \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

What date did the discrimination occur? \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use additional space on the next page if necessary):

Has a complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court? Yes  No

If yes, Agency or Court: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Filed: \_\_\_\_\_

Additional space for answers:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return Form to:  
**HR Director**  
**TCH**  
**215 West Lodge**  
**Drive**  
**Tempe, AZ 85283**

**Or by email at [kendellgans@tch-az.com](mailto:kendellgans@tch-az.com)**

Phone: (480) 730-4132  
Fax: (480) 730-5214