TCMH TEXAS COUNTY MEMORIAL HOSPITAL

ADA Complaint Procedures

If you have a complaint about the accessibility of our services or believe you have been discriminated against because of your disability, you can file a complaint. Please provide all facts and circumstances surrounding your issue or complaint so we can fully investigate the incident.

How do you file a complaint?

You can call us, download and use our ADA complaint form at (give web address), or request a copy of the form by writing or phoning Texas County Memorial Hospital 417-967-1324.

You may file a signed, dated and written complaint no more than 180 days from the date of the alleged incident. The complaint should include:

- Your name, address and telephone number. (See Question 1 of the complaint form.)
- How, why, and when you believe you were discriminated against. Include as much specific, detailed information as possible about the alleged acts of discrimination, and any other relevant information. (See Questions 6, 7, 8, 9, 10, and 11 of the complaint form.)
- The names of any persons, if known, whom the director could contact for clarity of your allegations. (See Question 11 of the complaint form.)

Please submit your complaint form to address listed below:

Texas County Memorial Hospital
Attn: April Crites
1333 S. Sam Houston Blvd.
Houston, MO 65483

Do you need complaint assistance?

If you are unable to complete a written complaint due to a disability or if information is needed in another format, such as braille or large print, we can assist you. Please contact us at 417-967-1324 or April.Crites@tcmh.org

How will your complaint be handled?

Texas County Memorial Hospital investigates complaints received no more than 180 days after the alleged incident. Texas County Memorial Hospital will process complaints that are complete. Once a completed complaint is received, Texas County Memorial Hospital will review it to determine if Texas County Memorial Hospital has jurisdiction.

Texas County Memorial Hospital will generally complete an investigation within 90 days from receipt of a complaint. If more information is needed to resolve the case, Texas County Memorial Hospital may contact you. Unless a longer period is specified by Texas County Memorial Hospital, you will have ten (10) days from the date of the request to send the requested information. If the requested information is not received, Texas County Memorial Hospital may administratively close the case. A case may also be administratively closed if you no longer wish to pursue it.

After an investigation is complete, Texas County Memorial Hospital will send you a letter summarizing the results of the investigation, stating the findings and advising of any corrective action to be taken as a result of the investigation. If you disagree with Texas County Memorial Hospital determination, you may request reconsideration by submitting a request in writing to Texas County Memorial Hospital Director of Quality and Risk Management within seven (7) days after the date of Texas County Memorial Hospital letter, stating with specificity the basis for the reconsideration. The Director of Quality and Risk Management will notify you of the decision either to accept or reject the request for reconsideration within ten (10) days. In cases where reconsideration is granted, the Director of Quality and Risk Management will issue a determination letter to the complainant upon completion of the reconsideration review.

Do I have other options for filing a complaint?

We encourage that you file the complaint with us. However, you may file a complaint with the Missouri Department of Transportation or the Federal Transit Administration.

Missouri Department of Transportation
External Civil Rights Division
Title VI Coordinator
1617 Missouri Blvd.
P. O. Box 270
Jefferson City, MO 65102-0270
www.modot.org

Federal Transit Administration
Office of Civil Rights
1200 New Jersey Avenue SE
Washington, DC 20590

TCMH TEXAS COUNTY MEMORIAL HOSPITAL

ADA COMPLAINT FORM

If you have a complaint about the accessibility of our transit system or believe you have been discriminated against because of your disability, you can use this form to file a complaint. Please provide all facts and circumstances surrounding your issue or complaint so we can fully investigate the incident.

Please mail or return this form to:

Texas County Memorial Hospital
Attn: Quality and Risk Management
1333 S. Sam Houston Blvd.
Houston, MO 65483
Phone: 417-967-1324
Fax: 417-937-3764

1. Complainant's name:
Address:
City: State: Zip Code:
Daytime telephone: ( )
E-mail address:
Do you prefer to be contacted via e-mail? ☐ Yes ☐ No
2. Are you filing this complaint on your own behalf? ☐ Yes If YES, please go to question 6. ☐ No If NO, please go to question 3.
3. Please provide your name and address. Name of person filing complaint:
Address:
City: State: Zip Code:
Daytime telephone: ( )
E-mail address:
Do you prefer to be contacted via e-mail? ☐ Yes ☐ No
4. What is your relationship to the person for whom you are filing the complaint?
5. Please confirm that you have obtained the permission of the aggrieved party to file a complaint on their behalf. ☐ Yes, I have permission. ☐ No, I do not have permission

6. I believe that the discrimination I experienced was based on (check all that apply)

☐ Accessibility issue ☐ Discrimination based on disability ☐ Other

7. Date of alleged discrimination (Month, Day, Year):

8. Where did the alleged discrimination take place?

9. Explain as clearly as possible what happened and why you believe that you were discriminated against. Describe all of the persons that were involved. Include the name and contact information of the person(s) who discriminated against you (if known). *Use the back of this form or separate pages if additional space is required.*

10. Please list any and all witnesses' names and phone numbers/contact information. *Use the back of this form or separate pages if additional space is required.*

11. What type of corrective action would you like to see taken?

12. Have you filed a complaint with any other federal, state, or local agency, or with any federal or state court? ☐ Yes If yes, check all that apply. ☐ No

☐ Federal Agency (List agency's name)

☐ Federal Court (Please provide location)

☐ State Court

☐ State Agency (Specify agency)

☐ County Court (Specify court and county)

☐ Local Agency (Specify agency)
13. Please provide information about a contact person at the agency/court where the complaint was filed.
Name: Title:
Agency: Telephone: ( )
Address
City: State: Zip Code:

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

Signature and date is required:

_____ _____

Signature Date

If you completed Questions 3, 4 and 5, your signature and date is required

_____ _____

Signature Date