Intermountain Health

Discrimination Complaint Form

If you feel you have been discriminated against while a patient or visitor in one of our facilities or while otherwise participating in one of our health programs or activities, please provide the information requested in this form. You are not required to use the form, but please include the requested information within the form. You may submit your complaint by:

- **Email:** ContactCompliance@imail.org
- **Mail:** Intermountain Health, Compliance Department (attn. Civil Rights Coordinator), 36 S. State St., Salt Lake City, UT 84111
- **In Person:** Please return the form to an Intermountain staff member, who will then direct it to the appropriate person
- **Phone:** 1-800-442-4845 (TTY Users: 711)

Note to staff – please scan and return or email this form to: ContactCompliance@imail.org

Please submit your complaint within 60 days of the alleged discriminatory action. Filing a complaint with Intermountain Health is voluntary. However, please provide as many details as possible so that we may be able to ensure a thorough investigation. If you have questions or need assistance with this form, please call 1-800-442-4845 (TTY Users: 711).

Today's Date

Email Address

First Name

Last Name

Street Address

Address Line 2

City

State

Zip

Phone Number (xxx)xxx-xxxx

Are you making this complaint on behalf of someone else as his/her personal representative?

◯ Yes

◯ No

If yes, does that individual know you are filing a complaint on his/her behalf?

I believe that I have been, or someone I am representing has been, discriminated against on the basis of:

☐ Age
☐ Race
☐ Color
☐ Ethnicity or National Origin (including limited English proficiency and primary language)
☐ Disability
☐ Sex (including sex characteristics and intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes),
☐ Religion
☐ Creed
☐ Socioeconomic Status
☐ Veteran Status
☐ Other (specify): _____

What is the name of the person you believe discriminated against you or the person you are representing? (if known)

Where did the alleged discrimination occur? (Department, Floor, Clinic, etc.)

Facility or location name (if known)

Street address (if known)

City | State | Zip Code

Date of incident or situation

Please describe what happened. Why do you believe that you have been, or someone you are representing has been, discriminated against? Be as detailed as possible.

What outcome are you hoping for to resolve this complaint?

We will use the information you provide to investigate the allegation of discrimination. We will allow all interested persons an opportunity to submit evidence relevant to the complaint. We will issue you a formal response in writing within 30 days of receiving the complaint. If you disagree with the decision communicated to you, you may send a written appeal (within 15 days of the receiving the decision) to ContactCompliance@imail.org or:

Intermountain Health
Compliance Department (attn: System Civil Rights Coordinator)
36 S. State Street
Salt Lake City, UT 84111

If applicable, you will receive a written response to your appeal within 30 days after the appeal is filed.

Intermountain Health

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

We provide language assistance and appropriate auxiliary aids and services free of charge. Please see staff for assistance.

Arabic	المساعدة على للحصول الفريق مراجعة يُرجى .مجانًا المناسبة الإضافية والخدمات والمساعدات اللغوية المساعدة نقدم.	العربية
Chinese	我们免费提供语言协助和适当的辅助工具及服务。如需帮助，请咨询工作人员。	中文
French	Nous fournissons gratuitement une assistance linguistique et des aides et services auxiliaires appropriés. Consultez le personnel pour obtenir de l'aide.	français
German	Wir bieten sprachliche Unterstützung und angemessene zusätzliche Hilfen und Dienstleistungen kostenlos an. Bitte wenden Sie sich an unser Personal, um Unterstützung zu erhalten.	Deutsch
Hindi	हम भाषा सहायता और उपयुक्त सहायक उपकरण व सेवाएं निःशुल्क प्रदान करते हैं। सहायता के लिए स्टाफ से मिलें।	हिन्दी
Italian	Forniamo supporto linguistico, ausili e servizi pertinenti gratuiti. Per assistenza, rivolgersi al personale.	italiano
Japanese	言語サポート、および適切な補助やサービスを無償でお届けします。対応スタッフをご確認ください。	日本語
Korean	저희는 언어 지원 서비스와 적절한 보조 장비 및 서비스를 무료로 제공합니다. 도움이 필요하면 직원에게 문의하십시오.	한국어
Portuguese	Fornecemos assistência linguística e auxílios e serviços auxiliares apropriados gratuitamente. Consulte a equipe para obter assistência.	português
Russian	Мы предоставляем языковую поддержку, а также необходимые вспомогательные средства и услуги бесплатно. Обратитесь за помощью к персоналу.	Русский
Somali	Waxa aanu bixinaa kaalmo luuqadeed iyo kaalmada maqalka ee haboon iyo adeegyo bilaash ah, U tag shaqaalaha wixii kaalmo ah.	Soomaali
Spanish	Ofrecemos asistencia lingüística, así como también ayuda y servicios auxiliares adecuados, de forma gratuita. Consulte al personal para obtener ayuda.	español
Tagalog	Naghahatid kami ng tulong sa wika at ng naaangkop na mga kasamang tulong at serbisyo nang libre. Makipag-ugnayan sa mga kawani para sa tulong.	Tagalog
Tongan	‘Oku mau fakahoko ‘a e tokoni ‘i he leá mo vahevahe ‘o ‘ikai ha totongi ‘a e ngaahi naunau mo e sēvesi tokoni ki ha faingata‘a‘ia fakaefetu‘utaki. Sio ki ha taha ngāue ke tokoni atu.	faka-Tonga
Vietnamese	Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ cùng với các dịch vụ và trợ giúp bổ sung phù hợp miễn phí. Vui lòng đến gặp nhân viên để được hỗ trợ.	tiếng Việt