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:

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.