**Notice of Nondiscrimination**

[Enter Provider Name] is a provider of health services and programs and is required to post this notice of nondiscrimination for all participants, beneficiaries, enrollees, applicants, and members of the public.

[Enter Provider Name] does not discriminate on the basis of race; color; national origin including limited English proficiency and primary language; sex; age; or disability.

[Enter Provider Name] will provide reasonable modifications for individuals with disabilities and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats such as braille or large print, free of charge when they are necessary to ensure accessibility and equal opportunity to participate.

Language assistance services are also available when necessary, including written and electronic translated documents and oral interpretation, free of charge.

If you need any of these services, please contact the Section 1557 Coordinator [Enter Section 1557 Coordinator Name and Contact Information].

If you feel you have been discriminated against, please complete a grievance form [Enter location of grievance forms or process]. You may also file a complaint with the Office of Civil Rights (OCR) by mailing a complaint form or calling:

Federal Coordination and Compliance Section – 4CON

Civil Rights Division

U.S. Department of Justice

950 Pennsylvania Ave, N.W.

Washington D.C. 20530

(888) 848-5306 (English and Spanish – ingles y Espanol)

(202) 307-2222 (voice)

(202) 307-2678 (TDD)

You can find more information on our nondiscrimination policies on our website [Enter web address].

This form will be provided to you on an annual basis, upon request, and is posted [enter posting location].

By signing below, I acknowledge that I have received this Notice of Nondiscrimination and been afforded the opportunity to ask questions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Program Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_