ALLIANCE DEFENDING FREEDOM

FOR FAITH. FOR JUSTICE.

May 21, 2019

Via E-Mail and U.S. Mail: OCRComplaint@hhs.gov

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Bldg.
Washington, DC 20201

Re: Complaint of Discrimination in Violation of Federal Statutes

Dear Sir or Madam:

Alliance Defending Freedom represents Caring Families Pregnancy Services, Inc., a not-for-profit corporation headquartered in Willimantic, Connecticut, with a satellite facility that serves Hartford, Connecticut. Caring Families is a pro-life pregnancy center and has been subjected to unlawful discrimination by the City of Hartford. Hartford is subject to the Church Amendments (42 U.S.C. § 300a-7), the Public Health Service Act (§ 245 (42 U.S.C. § 238n)), the Coats–Snowe Amendment (42 U.S.C. § 238n), and/or the Weldon Amendment (Continuing Appropriations Resolution, Pub. L. No. 113-164, Sec. 101(a) (Sept. 19, 2015)) by virtue of its status as a recipient of federal funding.

Caring Families provides medical and other services in conformance with its religious convictions that all human life should be respected at all stages, including life within the womb. These convictions prohibit Caring Families from performing, assisting in, referring for, or participating in any way with abortion or abortion-causing drugs. These convictions also compel Caring Families to serve the community by communicating truthfully about its beliefs. The rights of Caring Families to offer assistance to women in need without compromising its religious convictions relating to abortion are protected by the First Amendment to the United States Constitution and the Constitution of the State of Connecticut, in addition to the federal conscience laws named above.

1000 Hurricane Shoals Rd. N.E. Suite D-1100, Lawrenceville GA 30043
Phone: 800.835.5233 Fax: 770.339.6744 AllianceDefendingFreedom.org

Pursuant to Ordinance 25–17, signed into law by Mayor Luke Bronin effective October 1, 2018, and its implementing Rule, "pregnancy services centers" must provide a notice to clients on site, on their websites, and over the telephone in conversations with clients or potential clients, stating: "This facility does not have a licensed medical provider on site to provide or supervise all services." The Ordinance mandates this written and oral speech, even though many of Caring Families' services are not medical.

The Ordinance exempts abortion clinics, community health clinics, and all other health care facilities within Hartford, except for pregnancy centers that do not offer abortion. The Ordinance therefore unlawfully discriminates against organizations such as Caring Families that do not desire to perform, assist in, or refer for abortion services.

Because the Ordinance violates its right to practice medicine and serve the community according to its conscience and religious beliefs, Caring Families brought suit in the United States District Court for the District of Connecticut. The attached Complaint, *Caring Families v. City of Hartford*, No. 3:19-cv-00584 (filed April 18, 2019), contains the factual and legal descriptions of this violation of our clients' rights. The case is currently pending.

Please promptly inform us of the actions your office plans to take regarding this violation. Thank you for your attention to this matter.

Sincerely yours,

/s/ Denise M. Harle
Denise M. Harle, Esq.

cc: Kevin Theriot, Esq., Senior Counsel, Alliance Defending Freedom
Clients

Form Approved: OMB No. 0945-0002
Expiration Date: 04/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

Civil Rights Discrimination Complaint

YOUR FIRST NAME	YOUR LAST NAME
Denise	Harle
HOME PHONE (*Please include area code*)	WORK PHONE (*Please include area code*) (770) 339-0774

STREET ADDRESS	CITY
1000 Hurricane Shoals Rd. NE, Ste. D1100	Lawrenceville

STATE	ZIP	E-MAIL ADDRESS (*If available*)
GA	30043	dharle@adflegal.org

Are you filing this complaint for someone else? ☑ Yes ☐ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME
Caring Families Pregnancy Services, Inc.	

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ■ Religion / Conscience ☐ Sex
☐ Disability ☐ Other (specify):

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON / AGENCY / ORGANIZATION
City of Hartford

STREET ADDRESS	CITY
550 Main Street	Hartford

STATE	ZIP	PHONE (*Please include area code*)
Connecticut	06103	(860) 757-9311

When do you believe that the occurred?

LIST DATE(S)
Beginning October 1, 2018, effective date of the discriminatory ordinance.

Describe briefly what happened. How and why do you believe you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

See attached.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE Denise M. Harle DATE 5/20/19

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for OCR to communicate with you about this complaint? (*Check all that apply*)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE (*Please include area code*)	WORK PHONE (*Please include area code*)
STREET ADDRESS	CITY
STATE / ZIP	E-MAIL ADDRESS (If available)

Have you filed your complaint anywhere else? If so, please provide the following. (*Attach additional pages as needed*)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

U.S. District Court for the District of Connecticut

DATE(S) FILED	CASE NUMBER(S) (If known)
April 18, 2019	3:19-cv-00584

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (*select one*)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (*select one or more*)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English):

How did you learn about the Office for Civil Rights?

☐ HHS Website /Internet Search ☐ Family / Friend /Associate ☐ Religious /Community Org ☐ Lawyer /Legal Org ☐ Phone Directory ☐ Employer

☐ Fed /State/Local Gov ☐ Healthcare Provider /Health Plan ☐ Conference /OCR Brochure ☐ Other(*specify*):

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services

Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail this complaint form to this address.**

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☒ **CONSENT**: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED**: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: Denise M. Harle Date: 5/20/19

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): Denise M. Harle

Address: 1000 Hurricane Shoals Rd. NE, Ste. D1100, Lawrenceville, GA 30043

Telephone Number: (770) 339-0774