Discrimination Complaint Form

Instructions

Please complete the below form as best as you can. You have 180 days from the alleged discrimination to file a complaint. You **MUST** sign and date the form before mailing it back to the Department of Social Services.

Name (first and last) of person filing complaint: _____

_____

Email Address: _____

Home Address: _____

City/State/Zip Code: _____

Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____

Name (first and last) and position of person who discriminated against you:

_____

DSS Office Location: _____

_____

The alleged discrimination was based on a service or program provided by (*check all that apply*):

- ☐ Adult Services & Aging
- ☐ Child Care Services
- ☐ Child Protection Services
- ☐ Child Support Services
- ☐ Energy/Weatherization Assistance
- ☐ Medicaid/CHIP Services or Eligibility
- ☐ Recoveries & Fraud Investigations
- ☐ SNAP Program
- ☐ TANF Program
- ☐ Victims Services
- ☐ Other program or service not mentioned above, please specify below.

_____

Basis of the alleged discrimintation:

☐ Age ☐ Disability ☐ Religion ☐ National Origin
☐ Race ☐ Color ☐ Sex

How were you discriminated against? State what happened (briefly).

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Signature: _____

Date: _____