

DISCRIMINATION COMPLAINT

(614) 644-2703 or Toll Free 1-866-227-6353 TTY (614) 995-9961 or Toll Free 1-866-221-6700 FAX 614-752-6381

Assistance with completion of this form shall be provided.

1. Name: (Last)		(First)		(Middle Initial)	
Home Address (Number and Street)			2. Work Phone Number ()		
(City)		(Zip)		3. Home Phone Number ()	
4a. On what basis do you believe you have been discriminated against? <input type="checkbox"/> Race <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Color <input type="checkbox"/> National Origin <input type="checkbox"/> Citizenship/Participant Status (WIA Program Only) <input type="checkbox"/> Religion <input type="checkbox"/> Ancestry <input type="checkbox"/> Sex			4b. Program/Services Area <input type="checkbox"/> Adoption/Foster Care/Child Welfare <input type="checkbox"/> Unemployment <input type="checkbox"/> WIA <input type="checkbox"/> Medicaid <input type="checkbox"/> Health Services <input type="checkbox"/> Child Support <input type="checkbox"/> Food Stamps <input type="checkbox"/> TANF <input type="checkbox"/> Other _____		
5. Race of the complainant <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other			Sex of the Complainant <input type="checkbox"/> Male <input type="checkbox"/> Female		
6. Name the agency you believe has discriminated against you:				(County)	
7. Location: (Number and Street)		(City)		(State)	(Zip)
8. Name(s) and title(s) of who you believe discriminated against you:					
9. Date of alleged discrimination		10. Working/training site where you were located: (if applicable)			
11. Please explain why you believe the treatment or incident you experienced was because of your race, color, religion, national origin, age, disability, political affiliation or belief, and/or for WIA Participants: citizenship/participant status. (Please attach additional sheet(s) of paper, if necessary to fully state your complaint.)					
12. Date complaint written		13. Complainant's signature			
FOR OFFICE USE ONLY					
Complaint No.		BCR staff assigned (initials)		Date charge received	
County Agency (specify CSEA, PCSA, CDJFS, ODJFS, etc.)			Program (OWA, WIA, TANF, Food Stamps)		