DISCRIMINATION COMPLAINT FORM

COMPLAINANT: ____________________________________________________________

Address: __________________________________________________________________

City, State & Zip Code: __________________________________________________________________

Phone number: Home: __________________________________________________________________

Other: __________________________________________________________________

Complaint Filed by: __ (Self or Representative)

Phone number: Business: __________________________________________________________________

Other: __________________________________________________________________

May we call you at work? (check one) □Yes □No

If you have a representative, would you like us to send copies of all future correspondence to that person? (check one) □Yes □No
PERSON OR ENTITY WHO ALLEGEDLY DISCRIMINATED AGAINST THE COMPLAINANT:

Name: ________________________________________________________________

Office Location: _______________________________________________________

Program (R.I. Works, SNAP, Medicaid, Rehabilitation, etc.): ______________________

Phone Number: ________________________________________________________

COMPLAINANT WAS ALLEGEDLY DISCRIMINATED AGAINST BECAUSE OF (CHECK ALL THAT APPLY)

Race or Color: □       Sex: □        National Origin: □        Disability: □

Age: □       Religion: □        Political Beliefs: □

Language Access Services: ________________________________________________

Date when the alleged discrimination occurred: ________________________________

Please describe the alleged discrimination and how it has affected the complainant. Attach additional sheets if needed.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What remedies is the complainant asking?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Has this complaint been filed with any federal, state or local agency or court?  
\(\text{(Check one)}\)
- [ ] Yes
- [ ] No

If so, which agency or court: __________________________________________

Agency or Court Contact Person: _______________________________________

Does the complainant intend to file with another agency?  
\(\text{(Check one)}\)
- [ ] Yes
- [ ] No

Agency: ______________________________________________________________

Signature: ____________________________________________________________

(COMPLAINANT)

Date: __________________________________________________________________

Mail to: 
Community Relations Liaison Officer
RI Department of Human Services
25 Howard Avenue, Cranston, RI 02920

USDA is an equal opportunity Provider and Employer