Rhode Island Department of Human Services
Office of the Director
25 Howard Avenue, Cranston, RI 02920 • (401) 462-2971 (Voice) • TDD (401) 462-6239 or Relay RI 1-800-745-6575

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?
(Check one)
□Yes □No

If so, which agency or court:_____

Agency or Court Contact Person: _____

Does the complainant intend to file with another agency?
(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