RI Department of Human Services
Office of the Director
25 Howard Avenue, Cranston, RI 02920
(401) 462-6427
(Voice) TDD 1-800-745-6575

DISCRIMINATION COMPLAINT FORM

Complainant: _____
(Name)

Address: _____

City, State and Zip Code: _____

Phone number: Home: _____ Other:_____

Email (optional): _____

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email ☐ Other

Preferred Language (if not English): _____

Do you have a representative? ☐ Yes ☐ No

If you do have a representative, would you like us to send copies of all future correspondence to that person? (check one) ☐ Yes ☐ No

Representative: _____
(Name)

Address: _____

City, State and Zip Code: _____

Phone number: Home: _____ Other: _____

Email (optional): _____

Preferred method of Contact: ☐ Mail ☐ Phone ☐ Email ☐ Other

Complaint filed by: _____

Person or Entity Who Allegedly Discriminated Against the Complainant:

Name: _____

Office Location: _____

Program:

☐ **RIW** (Cash) ☐ **SNAP** (Supplemental Nutrition Assistance Program)
☐ **GPA (**General Public Assistance**)** ☐ **MPP** (Medicare Premium Payment Program)
☐ **LTSS** (Long-term Services and Supports) ☐ **CCAP** (Childcare Assistance Program)
☐ **SSP** (State Supplemental Payment Program) ☐ **KB** (Katie Beckett)
☐ **ACC** (Medicaid) ☐ **EAD** (Medicaid, Age 65 and over, blind or disabled*)*

Complainant Was Allegedly Discriminated Against Because Of
(Check all that apply)

☐ Race ☐ Color ☐ Sex (including gender identity or sexual orientation)
☐ National Origin ☐ Disability ☐ Age ☐ Religion ☐ Political Beliefs

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 requesting?

_____

_____

_____

_____

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: _____

Do you intend to file with another agency? (Check one) ☐ Yes ☐ No

Name of Agency: _____

Signature: _____ Date: _____
(Complainant)

Mail to:

Community Relations Liaison Officer
RI Department of Human Services
25 Howard Ave, Building 57, Room 4-39
Cranston, RI 02920

USDA is an equal opportunity Provider and Employer