SERVICE DELIVERY OR EMPLOYMENT DISCRIMINATION COMPLAINT

Children and Families | Health Services | Workforce Development
DCF-F-156-E | F-00166 | DETS-16707-E (R. 12/2013)

If you need help completing this form please contact:

Name - Equal Opportunity Coordinator	Phone (Voice) ( ) -	Phone (TDD) ( ) -
Name of Complainant		Phone ( ) -

Address (number, street, city, state, zip code)

Basis for Service Delivery or Employment Discrimination Complaint: In service delivery, discrimination is prohibited on the following basis: age, color, disability, national origin, religion, political belief or affiliation , marital status, familial or parental status, race, sex, gender identity, sexual orientation, genetic testing, or all or part of an individual's income is derived from any public assistance program, retaliation for filing a complaint, or for assisting with a complaint, opposing discrimination in a program, service or activity conducted or funded with federal assistance.

Employment discrimination is prohibited on the basis of: age (over 40), national origin or ancestry, arrest record, conviction record, color, creed or religion, disability or association with a person with a disability, genetic testing, honesty testing, marital status, pregnancy or childbirth, military service, race, sex, sexual orientation, use or non use of lawful products off the employer's premises during non-working hours. Employees may not be harassed in the workplace based on their protected status nor retaliated against for filing a complaint, for assisting with a complaint, or for opposing discrimination in the workplace. The Federal Health Care Provider Conscience Protection Laws prohibit recipients of certain federal financial assistance from discrimination against health care providers because of the provider's refusal or willingness to participate in sterilization procedures or abortions contrary to or consistent with the provider's religious beliefs or moral convictions. These protections apply to employment and service delivery; however, not all prohibited bases will apply to all programs and/or employment activities.

Name of the Agency and/or Employee or Employer Against Whom the Complaint is Filed.

Describe the action or treatment that you think was discriminatory. Include information about who, what, when, where, how, why, and the names, addresses and phone numbers of any witnesses, if you know them. Please be specific about the date of the last incident. You may write this on another sheet of paper if you need more room. In the space below, please say how many pages are attached, if you need to add pages.

Description of the Relief or Satisfaction you Want:

SIGNATURE - Complainant or Complainant Representative	Date Signed

Co-authored by: Departments of Children and Families, Health Services; and Workforce Development

The information below is to be completed by the person at the agency who receives your complaint, looks into it and responds to you.

INFORMAL COMPLAINT

Date Received	Received By	Title

Agency

Actions and Individual(s) to be Investigated:

Findings (Must be completed within 30 days):

Action Taken:

Further Action Required? ☐ Yes ☐ No

If yes, what action is recommended?

HOW TO FILE AN EMPLOYMENT OR SERVICE DELIVERY DISCRIMINATION COMPLAINT

Instructions for Completing Employment or Service Delivery Discrimination Complaint

If you feel that you have been treated differently because of your age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief or affiliation, military participation, or use or non use of lawful products off the employer's or service provider's premises during non-working hours, you may file a complaint. If you were wrongfully denied services, or if the treatment you received was separate or different from others, or if the program was not accessible to you, it may be discrimination.

IMPORTANT: If your application for service was not taken or your were told you were not eligible for a particular program, BUT you feel you are eligible, ask the provider for a pamphlet which explains how to request a local agency appeal process or State administrative hearing review. Your right to appeal a decision or to request a State administrative hearing does not need to be connected to a discrimination complaint.

You may file an informal discrimination complaint with your employer or service provider, or you may file a formal discrimination complaint with a state or federal agency. Complaints alleging discrimination on the basis of age in programs funded by U.S. Department of Agriculture, Food and Nutrition Services (USDA-FNS) must be filed directly with the USDA Office of Adjudication, 1400 Independence Avenue, S.W., Washington D.C. This complaint will be forwarded to the appropriate FNS Regional OCR within five (5) working days after receipt. No one may threaten or harass you for making a complaint. No one may threaten or harass your witnesses because they are willing to say what they saw, heard or experienced. Complaints filed under the Federal Health Care Provider Conscience Protection Laws must be filed directly with HHS Office of Civil Rights.

All formal complaints must be filed within 180 days of the event or treatment you feel was discrimination. However, you should file the complaint as soon as possible after the action took place. IF you file an informal complaint and you are not satisfied with the resolution, you can still file a formal complaint as long as you do it within filing time frame. Do not wait until after the filing deadline to get an answer to the informal complaint if you plan to make a formal complaint.

To file an informal discrimination complaint with your provider or employer, request a discrimination complaint form by calling the Equal Opportunity Coordinator at - - or TDD - - .

Send the completed form back to your provider's Equal Opportunity Coordinator. His or her name should be on this form.

If you wish to file a formal discrimination complaint, you may send the completed complaint form directly to the appropriate state or federal agency listed on the following pages. Include a letter stating that you are making a formal complaint to their agency as the funding source. Staff of the state or federal agency will provide the results to you within 90 days.

File formal discrimination complaints about these services with the state agency listed below.

PROGRAM	STATE AGENCY
Wisconsin (WI) Works (W-2), (W-2) Transitions, Temporary Assistance to Needy Families (TANF), Brighter Futures Initiative, Child Support, Early Care and Education, Head Start, Child Care and Day Care Certification Programs, Child Welfare, Milwaukee Child Welfare and Integration Programs, Emergency Assistance, Families and Economic Security, Community Service Jobs, Job Access Loans, Adoption and Foster Care Programs, Safety and Permanence Programs (Out-of-Home Care, Safety and Well Being, Program Integrity), Child Placement Services, Child Abuse and Neglect, Protective Services, Kinship Care, Domestic Abuse/Domestic Violence Programs, and other programs administered by the WI Department of Children and Families. Refugee and Immigrant Services (Social Services, Older Refugee, Family Strengthening, Health Services, Preventative Health Services, Mental Health, Refugee Cash and Medical Assistance)	**WI Department of Children and Families** 201 E. Washington Ave, Second Floor P.O. Box 8916 Madison, WI 53708-8916 608-266-5335 (voice) 800-864-4585 (TTY)
Medical Assistance Services, Medicaid, BadgerCare Plus, FoodShare (formerly Food Stamps Program in Wisconsin), TEFAP, SeniorCare, Community Aid, Long Term Care, Mental Health and Substance Abuse, Services to the Deaf and Hard of Hearing, Blind and Visually Impaired and Persons with Disabilities, Family Care, Public Health Services, Community Health Center Programs, WIC (Women, Infants and Children), and other programs administered by the WI Department of Health Services	**WI Department of Health Services** Office of Affirmative Action and Civil Rights Compliance 1 W. Wilson, Room 656 P.O. Box 7850 Madison, WI 53707 608-266-9372 (voice) 608-266-0583 (fax) 888-701-1251 (TTY) or Wisconsin Relay 711
Wisconsin Workforce Investment Act, and other programs administered by the Wisconsin Department of Workforce Development.	**WI Department of Workforce Development** ATTN: Equal Opportunity Officer 201 E. Washington Ave, Room G100 P.O. Box 7972 Madison, WI 53707-7972 608-266-6889 (voice); 866-275-1165 (TDD)
Unsubsidized and Trial Jobs Complaints. Any employment condition as an employee of DCF, DHS and/or DWD funded entities and their subcontractors.	**Equal Rights Office** P.O. Box 8928 Madison, WI 53708 608-266-6860 (voice) : 608-264-8752 (TDD) **Equal Rights Office** 819 North Sixth Street, Room 255 Milwaukee, WI 53203 414-227-4384 (voice); 414-227-4081 (TDD) **U.S. Equal Employment Opportunity Commission** Reuss Federal Plaza 310 West Wisconsin Ave., Suite 800 Milwaukee, WI 53203-2292 800-669-4000 (voice) 414-297-4133 (fax); 800-669-6820 (TTY) **Milwaukee District Office** U.S. Department of Labor, OFCCP Federal Building 310 West Wisconsin Avenue, Suite 1115 Milwaukee, WI 53203 414-297-3821 (voice); 414-297-4038 (fax)

You also have the right to file a formal complaint with a federal agency listed below.

PROGRAM	FEDERAL AGENCY
Formal Discrimination Complaints about any of the above services administered by the Wisconsin Department of Health Services. Formal Discrimination Complaints filed based on the Federal Health Care Providers Conscience Protection Law.	**Office for Civil Rights** **U.S. Department of Health and Human Services** 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019 (voice, toll free) 800-537-7697 (TDD toll free) **U.S. Dept. of Health and Human Services** **Office for Civil Rights – Region V** 233 N. Michigan Ave., Suite 240 Chicago, IL 60601 800-368-1019 (voice, toll free) 312-886-1807 (fax) 800-537-7697 (TDD, toll free)
Formal Discrimination Complaints about any program receiving federal assistance.	**Coordination and Review Section - NWB** **Civil Rights Division** **U.S. Department of Justice** 950 Pennsylvania Avenue, NW Washington, D.C. 20530 888-848-5306 - English and Spanish (ingles y español) 202-307-2222 (voice) 202-307-2678 (TDD) **Title VI Hotline:** 1-888-TITLE-06 (1-888-848-5306) (Voice / TDD) **Disability Complaints:** **U.S. Department of Justice** **Civil Rights Division** 950 Pennsylvania Avenue, NW Disability Rights Section - NYAV Washington, DC 20530 800-514-0301 (voice) 800-514-0383 (TTY) (also in Spanish)
If you wish to file a Civil Rights Program of Discrimination with the USDA for the Supplemental Nutrition Assistance Program (SNAP) (Formerly known as the Food Stamp Program at the Federal level) FoodShare (Formerly known as the Food Stamps in Wisconsin), WIC, TEFAP and the Food Stamp Employment and Training (FSET) Program **complete the USDA Program Discrimination Complaint** found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call 866-623-9992 to request a form.	USDA Director, Office of Adjudication 1400 Independence Avenue, SW Washington, D.C. 20250-9410 866-632-9992 (request a form) Email: program.intake@usda.gov 800-877-8339 (Federal Relay Services) 800-845-6136 (Spanish)

COMPLAINANT CONSENT / RELEASE

Children and Families DCF-F-157 | Health Services F-00167 | Workforce Development DETS-16708-E (R. 12/1/2013)

Complainant's Name			Date Completed	
Address		City	State	Zip Code
Telephone Number - -	Cell Phone Number - -	Email Address		

Program(s) for which this Consent / Release form applies

Please read the information below, initial the appropriate space, sign and date this form.

I have read the Notice of Investigatory Uses of Personal Information by DCF, DHS or DWD. As a complainant, I understand that in the course of a preliminary inquiry or investigation it may become necessary for DCF, DHS or DWD to reveal my identity to persons at the organization or institution under investigation. I am also aware of the obligations of DCF, DHS or DWD to honor requests under the Freedom of Information Act. I understand that it might be necessary for DCF, DHS or DWD to disclose information, including personally identifying details, which it has gathered as a part of its preliminary inquiry or investigation of my complaint. In addition, I understand that, as a complainant, I am protected by federal regulations from intimidation or retaliation for having taken action or participated in an action to secure rights protected by nondiscrimination statutes enforced by the federal government.

CONSENT / RELEASE

CONSENT GRANTED - I have read and understand the above information and authorize DCF, DHS or DWD to reveal my identity to persons at the organization or institution under investigation and to other federal agencies that provide federal financial assistance to the organization or institution or also have civil rights compliance oversight responsibilities that cover that organization or institution. I hereby authorize DCF, DHS or DWD to receive material and information about me pertinent to the investigation of my complaint. This release includes, but is not limited to, applications, case files, personal records, and or medical records. I understand that the material and information will be used for authorized civil rights compliance and enforcement activities. I further understand that I am not required to authorize this release, and I do so voluntarily. Place your Initials on this line if you give consent: ___*(Initials)*.

CONSENT DENIED - I have read and understand the information and do not want DCF, DHS or DWD to reveal my identity to the organization or institution under investigation, or to review, receive copies of, or discuss material and consent information about me, pertinent to the investigation of my complaint. I understand that this is likely to make the investigation of my complaint and getting all the facts more difficult and, in some cases, impossible, and may result in the investigation being closed. Place your Initials on this line if you do not give consent: ___*(Initials)*.

SIGNATURE - Complainant or Complainant Representative	Date Signed (mm/dd/yyyy)