

Ohio Department of Job and Family Services
DISCRIMINATION COMPLAINT

Bureau of Civil Rights
30 E. Broad Street, 30th Floor
Columbus, Ohio 43215-3414
(614) 644-2703 or Toll Free 1-866-227-6353 FAX 614-752-6381
Assistance with completion of this form shall be provided.

1. Name: <i>(Last)</i>		<i>(First)</i>		<i>(Middle Initial)</i>	
Home Address <i>(Number and Street)</i>			2. Work Phone Number <i>(###) ### - ####</i>		
<i>(City)</i>		<i>(Zip)</i>		3. Home Phone Number <i>(###) ### - ####</i>	
4a. On what basis do you believe you have been discriminated against? <input type="checkbox"/> Race <input type="checkbox"/> Color <input type="checkbox"/> Religion <input type="checkbox"/> Sex <input type="checkbox"/> Disability <input type="checkbox"/> National Origin <input type="checkbox"/> Age <input type="checkbox"/> Political Belief (Food Stamps Only)			<u>WIOA Program Only</u> <input type="checkbox"/> Political Affiliation or Belief <input type="checkbox"/> Citizenship/ Participant Status		4b. Program/Services Area <input type="checkbox"/> Adoption/Foster Care/Child Welfare <input type="checkbox"/> Unemployment <input type="checkbox"/> WIOA <input type="checkbox"/> Child Support <input type="checkbox"/> Health Services <input type="checkbox"/> TANF <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other _____
5. Race of the Complainant <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other _____			6. Complainant's Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	7. Sex of the Complainant <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Name the agency you believe has discriminated against you:				<i>(County)</i>	
9. Location: <i>(Number and Street)</i>		<i>(City)</i>		<i>(State)</i>	<i>(Zip)</i>
10. Name(s) and title(s) of who you believe discriminated against you:					
11. Date of alleged discrimination		12. Working/training site where you were located: <i>(if applicable)</i>			
13. Please explain why you believe the treatment or incident you experienced was because of your race, color, religion, national origin, age, sex, disability, political affiliation or belief, and/or for WIOA Participants: citizenship/participant status. (Please attach additional sheet(s) of paper, if necessary to fully state your complaint.)					
14. Date complaint written		15. Complainant's signature			
FOR OFFICE USE ONLY					
Complaint No.		BCR staff assigned <i>(initials)</i>		Date charge received	
County Agency <i>(specify CSEA, PCSA, CDJFS, ODJFS, etc.)</i>			Program <i>(OWA, WIOA, TANF, Food Stamps)</i>		