Reset Form

Ohio Department of Job and Family Services
Bureau of Civil Rights
30 E. Broad Street, 37th Floor
Columbus, Ohio 43266-0423

DISCRIMINATION COMPLAINT FORM

(614) 644-2703 or Toll Free 1-800-227-6353 TTY (614) 995-9961 or Toll Free 1-866-221-6700 FAX (614) 752-6381

Assistance with completion of this form shall be provided.

1. Name: *(Last)* *(First)* *(Middle Initial)*

Home Address:

(Number and Street)

(City) *(Zip)*

2. Work Phone Number

( )

3. Home Phone Number

( )

4a. On what basis do you believe you have been discriminated against?

- ☐ Race
- ☐ Age
- ☐ Disability
- ☐ Color
- ☐ National Origin
- ☐ Citizenship/Participant Status (WIA Program Only)
- ☐ Religion
- ☐ Ancestry
- ☐ Sex

4b. Program/Services Area

- ☐ Adoption/Foster Care/Child Welfare
- ☐ Unemployment
- ☐ WIA
- ☐ Medicaid
- ☐ Health Services
- ☐ Child Support
- ☐ Food Stamps
- ☐ TANF
- ☐ Other

5. Race of the complainant:

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Hispanic/Latin
- ☐ Native American
- ☐ Asian/Pacific Islander
- ☐ Other

Sex of the Complainant:

- ☐ Male
- ☐ Female

6. Name the agency you believe has discriminated against you: *(County)*

7. Location *(Number and Street)* *(City)* *(State)* *(Zip)*

8. Name(s) and title(s) of who you believe discriminated against you:

9. Date of alleged discrimination

10. Working/training site where you were located: *(if applicable)*

11. Please explain why you believe the treatment or incident you experienced was because of your race, color, religion, national origin, age, disability, political affilliation or belief, and/or for WIA Participants: citizenship/participant status. (Please attached additional sheet(s) of paper, if necessary to fully state your complaint.)

12. Date complaint written

13. Complainant's signature

FOR OFFICE USE ONLY

Complaint No.

BCR staff assigned: *(initials)*

Date charge received:

County Agency: (specify CSEA, PCSA, CDJFS, ODJFS, etc.)

Program: (OWA, WIA, TANF, Food Stamps)