

DISCRIMINATION COMPLAINT FORM

If you need help completing this form please contact: Kristine Reddy at kreddy@anufs.org

Name - Equal Opportunity Coordinator: Kristine Reddy	Phone (Voice) 715-386-1547	Phone (TDD) 711-715-386-1547
Name of Complainant		Phone - -
Address (number, street, city, state, zip code)		

Federal civil rights laws prohibit discrimination of MEMBERS, APPLICANTS, ENROLLEES, AND BENFICIARIES in any programs and activities that receive Federal financial assistance and that are run by State Agencies (DHS/DCF) directly or by their partners, local agencies, and contractors. Those laws prohibit recipients and subrecipients of Federal financial assistance from discriminating on the basis of race, color, national origin, sex, age, disability, and, in some programs, religious creed or political affiliation or beliefs, in their programs or activities, and in retaliating or engaging in reprisals against for opposing discrimination. If you were wrongfully denied services, or if the treatment you received was separate or different than others received, or if the program was not accessible to you, and you believe is was because of one or more of those protected bases, it may be discrimination. The precise nondiscrimination requirements depend on which Federal agency funds the program or activity.

Name of the Agency/Organization/Entity against whom the complaint is filed.

Name of the Federal program you were discriminated in by the agency/organization (e.g., BadgerCare, FoodShare, Child Protective Services, etc.)

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 remedy you want:

SIGNATURE - Complainant or Complainant Representative	Date Signed (mm/dd/yyyy)
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The information below is to be completed by the person at the entity who receives your complaint and investigates it.

Date Received	Received By	Title
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Agency

Actions and Individual(s) to be investigated:

Findings (Must be completed within 90 days):

Action Taken:

Further Action Required? Yes No If yes, what action is recommended?