

## Civil Rights Service Delivery Discrimination Complaint

**Use of form:** This form should be used when filing the following types of discrimination complaints: service delivery (Title VI), ADA and Section 504 complaints. When completing this form refer to the instructions following this form. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

---

### SECTION I – COMPLAINANT INFORMATION

Name (First, MI, Last)

Address (Street, City, State, Zip Code)

Telephone Number – Home (Include area code)

Telephone Number – Work (Include area code)

Email Address

---

### SECTION II – COMPLAINANT REPRESENTATIVE INFORMATION

Yes  No Are you a representative filing this complaint on behalf of someone else?  
If “Yes”, what is your relationship to the complainant?

Name – Representative (First, MI, Last)

Address (Street, City, State, Zip Code)

Telephone Number – Home (Include area code)

Telephone Number – Work (Include area code)

Email Address

---

### SECTION III – BASIS OF ALLEGED DISCRIMINATION

I believe that I have been discriminated against on the basis of: (Only check the boxes that are the reasons(s) for the alleged discrimination complaint.)

Race  Color  Age  Gender  Disability  Religion  National origin or ancestry  
 Other – Specify:

---

### SECTION IV – INFORMATION ABOUT THE ALLEGED DISCRIMINATION

Provide information about the alleged discrimination including the name(s) of the person(s), the agency name(s), address(s) and telephone number(s) (including the area codes).

---

List the dates that you believe the discrimination took place.

---

---

Briefly describe the specific alleged discrimination. If additional space is needed, attach separate pages.

---

**SECTION V – COMPLAINANT SIGNATURE**

---

Sign and date this complaint.

\_\_\_\_\_

Complainant Signature

\_\_\_\_\_

Date Signed

Without the information requested above, the Wisconsin Department of Children and Families (DCF) Civil Rights Compliance (CRC) Unit may be unable to proceed with investigating your complaint. We will use the information you provided to determine if we have jurisdiction to investigate your complaint. If the DCF CRC Unit does have jurisdiction to investigate your complaint, we will use the information you have provided to begin our investigation.

You are not required to use this form (DCF-F-2466-E). You may also write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, contact the DCF Equal Opportunity Officer, at (608) 422-6889.

Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed only when it is necessary for the investigation of possible discrimination, for internal systems operations, or for other routine uses, which may include the disclosure of information outside of DCF for purposes associated with civil rights compliance and as permitted by law.

---

**SECTION VI – OPTIONAL INFORMATION**

---

Providing the remaining information on this form is optional. Failure to provide this information will not affect whether DCF processes your complaint.

---

**Language Assistance and Special Accommodations**

---

Do you need special accommodations for us to communicate with you about this complaint? Check all that apply.

- Braille    Large print    Electronic mail    Wisconsin Relay Service ( WRS)-711  
 Sign language interpreter  
 Foreign language interpreter  
 Primary language spoken:  
 Other – Specify:

---

**Other Agency(s) This Complaint Has Been Filed With**

---

- Yes    No   Have you filed your complaint anywhere else?  
If "Yes", provide the following information. Attach additional pages as needed.

Person(s), agency(s), organization(s), court name(s) where you have filed your complaint.

---

Date(s) complaint was filed

---

Case Number(s), if known

---

**Demographic Data Collection**

To help us better serve the public, provide the following demographic information about yourself.

- Ethnicity – Select one.    Latino    Not Hispanic or Latino  
Race – Select one or more.    White    Black or African American    American Indian  
 Asian    Native Hawaiian or Other Pacific Islander  
 Other – Specify:

---

How did you learn about the DCF Civil Rights Compliance Unit? – Specify.

## HOW TO FILE A SERVICE DELIVERY DISCRIMINATION COMPLAINT

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, other civil rights laws, and the United States (U.S.) Department of Health and Human Services (DHHS), implementation regulation – 45 Code of Federal Regulations (CFR) Part 80, prohibit discrimination in service delivery by agencies that receive federal financial assistance.

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, you may file a service delivery discrimination 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.

It is illegal for agencies that receive federal financial assistance from the United States (U.S.) Department of Health and Human Services (DHHS) to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under federal civil rights laws.

**IMPORTANT:** If your application for service was not taken or you 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.

### HOW DO I FILE A FORMAL SERVICE DELIVERY DISCRIMINATION COMPLAINT?

To file a formal service delivery discrimination complaint about any of the programs listed on this complaint form or other programs administered or funded by the Department of Children and Families, you may complete the DCF Civil Rights Service Delivery Discrimination Complaint form (DCF-F-2466-E) and mail to:

Department of Children and Families  
Division of Management Services  
Civil Rights Compliance Unit  
201 W. Washington Ave  
P.O. Box 8916  
Madison, WI 53703-8916

Voice: (608) 422-6889  
TTY: Wisconsin Relay Service (WRS) - 711

You may also file a formal complaint at the federal level with the United States (U.S.) Department of Health and Human Services (DHHS) or the U.S. Department of Justice (DOJ) for any of the programs administered by the Department of Children and Families. Their contact information is provided on the last page of this form for your convenience.

### WHAT ARE THE TIMELINES FOR FILING A FORMAL COMPLAINT?

All formal complaints must be filed within 180 days of the event or treatment you feel was discriminatory. However, you should file the complaint as soon as possible after the action took place. 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.

## INSTRUCTIONS ON HOW TO COMPLETE THE DISCRIMINATION COMPLAINT

### SECTION I – COMPLAINANT INFORMATION

Provide your name, address, telephone number and other contact information as requested.

### SECTION II – COMPLAINANT REPRESENTATIVE INFORMATION

Complainants have the right to ask for assistance when filing a discrimination complaint. The complainant may also ask someone else to represent or accompany him / her throughout the complaint filing process. If you are filing this complaint for someone else, print your name, address, telephone number and other contact information as requested.

### SECTION III – BASIS OF ALLEGED DISCRIMINATION

Check the box(s) that you believe describe the basis of the alleged discrimination that you experienced.

### SECTION IV – INFORMATION ABOUT THE ALLEGED DISCRIMINATION

- Provide the name(s), address(s) and telephone number(s) (including the area codes) of the person(s) and / or agency(s) that you believe discriminated against you.
- List the date(s) the discrimination occurred.
- Briefly describe the specific alleged discrimination. If additional space is needed, attach separate pages.

### SECTION V – COMPLAINANT SIGNATURE

Provide your signature and the date the form was signed to certify your complaint.

### SECTION VI – OPTIONAL INFORMATION

Completion of the following sections of the form is voluntary.

#### Language Assistance and Special Accommodations

Indicate if you need language assistance or other accommodations. Check all items that apply. If you checked "Other", specify what accommodation you might need due to a disability(s) that is not listed.

#### Other Agency(s) This Complaint Has Been Filed With

Provide the name(s) of the agency(s) or organization(s) that you have filed this complaint with. Include the name(s) of the person(s) involved and the date the complaint(s) was filed. Include the case number, if known.

#### Demographic Data Collection

To help us better serve the public, indicate your ethnicity and race. The information that you provide will be used for statistical purposes only to help us better understand the population(s) that we serve.

