Reset Form

Ohio Department of Job and Family Services
Bureau of Civil Rights
30 E. Broad Street, 37th Floor
Columbus, Ohio 43215-3414

DISCRIMINATION COMPLAINT

(614) 644-2703 or Toll Free 1-866-227-6353 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	State / 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/Latino
☐ 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 affiliation 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)*	