

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
COMPLAINT FORM**

Complainant Information		
First name	Middle Initial	Last Name
SSN:		DOB:
Mailing Address (Include Full City, State and Zip Code)		
Primary Phone Number	Alternate Phone Number	Email
Best way to reach you: <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Other		
<p>IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, CONTACT YOUR LOCAL DHS OFFICE at 1-855-372-1084. Si necesita este formulario en Español, llame al 1-855-372-1084 y pida la versión en Español. For TDD/TTY services, please contact Arkansas Relay at 1-800-285-1131 for English or 1-866-656-1842 for Spanish. Para servicios TDD/TTY, comuníquese con Arkansas Relay al 1-800-285-1131 para inglés o al 1-866-656-1842 para español.</p>		
Representative Information		
Do you have a representative? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have written authorization from representative? If so, please attach. <input type="checkbox"/> Yes <input type="checkbox"/> No
First name	Last Name	
Mailing address (Include Full City, State and Zip Code)		
Phone	Email	
Complaint Information <i>(attach additional pages and supporting documentation as needed)</i>		
1. Provide the name of the program for which you are filing a complaint.		
2. Date of recent alleged discrimination/incident (mm/dd/yyyy)	3. Location and/or address of the office where discrimination/incident occurred	
4. Were you treated in a courteous manner? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, were you talked to or treated rudely? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		
5. Do you believe that you were served in a timely manner? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain Have you provided the county with the requested information, but your case has not been processed? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
COMPLAINT FORM**

6. In your opinion, were you discriminated against? Yes No

It is a violation of the law to discriminate against you based on the following: race, color, national origin, religion, sex including gender identity and expression, sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, and political beliefs.

I believe I was discriminated against based on:

- | | | |
|---|---|--|
| <input type="checkbox"/> Race | <input type="checkbox"/> Sex | <input type="checkbox"/> Marital Status |
| <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Gender Identity (Expression) | |
| <input type="checkbox"/> Color | <input type="checkbox"/> Disability | <input type="checkbox"/> Family/Parental Status |
| <input type="checkbox"/> National Origin | <input type="checkbox"/> Age | <input type="checkbox"/> Income from Public Assistance |
| <input type="checkbox"/> Political Beliefs | <input type="checkbox"/> Religion | <input type="checkbox"/> Retaliation (prior civil rights activity) |

7. What happened to you (please include dates of each allegation)?

8. Do you have other concerns?

Remedies

9. How would you like to see this complaint resolved?

10. Have you filed a complaint about the incident(s) with another federal, state, or local agency or with a court?

11. If yes, with what agency or court did you file?

12. If yes, when did you file?
(mm/dd/yyyy)

Complainant Signature

Date

Representative Signature

Date

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
COMPLAINT FORM**

NON – DISCRIMINATION STATEMENT

This institution is an equal opportunity provider.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed AD-3027 form, or letter must be submitted to:

US MAIL:

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

Fax: (833) 256-1665 or (202) 690-7442; or

Email:

FNCSIVILRIGHTSCOMPLAINTS@usda.gov

FOR COUNTY USE ONLY

RESOLUTION (To be completed by County Office/OPGM)

1. Result of Investigation Substantiated Unsubstantiated

2. Description of Corrective Action Taken _____

Complaints can be filed with the Arkansas Department of Human Services, the USDA Office of the Assistant Secretary for Civil Rights or both.

Office of Program and Grant Management
P.O. Box 1437-Slot-S335
Little Rock, AR 72203-1437
Call (501) 534-4119
TDD/TTY: 800-285-1131
DCOCivilRightsComplaints@dhs.arkansas.gov

USDA Dept. of Agriculture Office of the Assistant Secretary for Civil Rights
1400 Independence Ave SW
Washington, DC 20250-9410
program.intake@usda.gov
Voice / TDD: 202-720-5964

INSTRUCTIONS

PURPOSE: The DHS (110) Complaint Form may be used to file a complaint if you believe you have experienced discrimination, rude treatment, or untimely processing for any DHS program. This form was designed to standardize the complaint reporting process within the Department and to provide a tracking system to ensure that corrective action has been taken. Both Civil Rights complaints and Non-Civil Rights complaints are to be recorded utilizing this form.

You are not required to use this form to file a discrimination complaint, you may send a letter or email instead of this form. The letter or email must include the information requested in items 1-12 on this form. If you decide to use this form, please type or print all information in items 1-12 of this form and use additional pages if more space is needed. If you need assistance completing this form, call (501) 534-4119.

Pursuant to 7 CFR 16.4(d), beneficiaries and prospective beneficiaries in programs supported by indirect financial assistance from USDA may file written complaints with USDA alleging violations of the rule's religious freedom protections by contacting or filing a written complaint with USDA's Office of the Assistant Secretary for Civil Rights (OASCR).

If you need assistance filling out this form (including translation services), you may call (501) 534-4119; assistance will be available in English and for individuals who are not proficient in English or in other languages. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

We must have a signed copy of your complaint. An incomplete or unsigned form or letter will delay processing of your complaint.

FILING DEADLINE: A program discrimination complaint must be filed within 180 days from the date you knew or should have known of the alleged discrimination unless the time for filing is extended. Complaints sent by mail are considered filed on the date the complaint is received. Complaint documentation or Complaint Forms sent by email will be considered filed on the date the complaint is received. Complaints filed after the 180-day deadline must include a 'good cause' explanation for the delay. For example, if:

1. You could not reasonably have been expected to know of the discriminatory act within the 180-day period;
2. You were seriously ill or incapacitated; or
3. The same complaint was filed with another Federal, state, or local agency and that agency failed to act on your complaint.

Guidelines for Completion

Complete the necessary identifying information: name, SSN, date of birth, mailing address, city, state, zip code and phone number.

1. Complete the representative information if applicable.
2. List the DHS program of which you are filing a complaint.
3. List the DHS County Office of which you are filing a complaint.
4. Enter the date of the incident.
5. Check yes or no if you feel the worker was discourteous or if you were treated rudely. If yes, please explain.
6. Check yes or no if you feel you were served in a timely manner and if requested information has been provided.
7. Check yes or no if you feel you were discriminated against.
8. Check each box that shows why you believe you were discriminated against.
9. Write and describe in a few words what happened that caused you to file a complaint. Use an additional sheet of paper, if necessary.
10. If you have other concerns, list here.
11. Please provide information on how you'd like this issue to be remedied.
12. Give information regarding any other complaints filed.

Sign and date the form.

FOR COUNTY USE ONLY:

This section is to be completed by an employee of the county office or the Office of Program and Grant Management.

1. Check the result of the investigation
2. Describe the corrective action taken to correct the situation. Use an additional sheet of paper, if necessary.

ROUTING

Non-Civil Rights – Original & 1 copy – Route to county office (if complaint is filed in office other than county office) Copy 2 – Originating office (if different than county office)
Copy 3 – Submit to Area Director by county office upon resolution

Civil Rights – Original – Submit to the Office of Program and Grant Management-SNAP Unit- P.O. Box 1437-Slot-S335 Little Rock, AR 72203-1437.

Copy – County Office

Copy – Area Director

*If disability is checked, submit copy to ADA Coordinator