

COMPLAINT UNDER AMERICANS WITH DISABILITIES ACT (TITLE II)

Michigan Department of Human Services

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 2.

Complainant Name:

Address:

City	State	Zip Code
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Telephone: Home: Business:

Person Completing This Form: (if other than the complainant)

Address:

City	State	Zip Code
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Telephone: Home: Business:

County/Program that you believe has discriminated against you:

Name:

Address:

County:

City	State	Zip Code
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Telephone Number:

When did the event occur? Date:

Describe the event providing the name(s) where possible for the individuals who were involved (use space on page 2 if necessary):

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Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other federal agency or court?

Yes No

If yes give name of agency or court:

Contact Person:

Address:

City	State	Zip Code
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Telephone Number:

Date Filed:

Do you intend to file with another agency or court?

Yes No

Agency or Court:

Address:

City	State	Zip Code
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Telephone Number:

Additional space for answers:

Signature:	Date
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Return to:
 Mary Hall-Thiam
 Office of Equal Opportunity and Diversity Programs
 PO Box 30037
 Lansing, MI 48909
 Phone: (517) 373-8520
 Fax: (517) 335-6453

<p>Authority: Sec.709(c), Title VII, Civil Rights Act of 1969, as amended.</p> <p>Response: Voluntary</p> <p>Penalty: None</p>	<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>
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