

DFCS Civil Rights Discrimination Complaint Form

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You may also file your complaint with the Georgia Division of Family and Children Services or the Georgia Department of Human Services, as follows:

For complaints based on national origin (e.g., limited English proficiency), vision and/or hearing impairment, contact:

Program Director
DHS LEP/SI Program
2 Peachtree Street, N.W., Suite 29-103
Atlanta, GA 30303
(404) 657-5244 (voice)
(404) 651-6815 (fax)
(404)-463-7591 (TTY)

For all other discrimination complaints, contact:

Program Officer
DFCS Civil Rights Program
2 Peachtree Street, N.W., Suite 19-244
Atlanta, GA 30303
(404) 657-3735 (voice)
(404) 463-3978 (fax)
(404)-463-7591 (TTY)



YOU HAVE A RIGHT TO FREE INTERPRETER SERVICES.

County Office where violation occurred		Date the discrimination occurred	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
FIRST NAME		LAST NAME	DATE OF BIRTH / /
HOME PHONE () -		ALTERNATE PHONE () -	
STREET ADDRESS			CITY
STATE		ZIP	E-MAIL ADDRESS (If available)
Is this complaint being filled out for someone else? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, include your name below: FIRST NAME _____ LAST NAME _____ CONTACT INFORMATION: _____			Do you wish to remain Anonymous? <input type="checkbox"/> YES <input type="checkbox"/> NO

I believe that I have been (or someone else has been) discriminated against on the basis of:

<input type="checkbox"/> Race	<input type="checkbox"/> Color
<input type="checkbox"/> Sex (Gender)	<input type="checkbox"/> Age
<input type="checkbox"/> Religion (Food Stamp Program Only)	<input type="checkbox"/> Political Beliefs (Food Stamp Program Only)
<input type="checkbox"/> National Origin:	<input type="checkbox"/> Disability:
<input type="checkbox"/> Limited English Proficient	<input type="checkbox"/> Vision Impairment
	<input type="checkbox"/> Hearing Impairment

Who do you think discriminated against you (or someone else)? Please list all persons who you think discriminated against you.
Be specific (Attach additional pages as needed)

PERSON/ AGENCY / ORGANIZATION _____

STREET ADDRESS		CITY
STATE	ZIP	PHONE () -

Describe briefly what happened. How and why do you believe you (or someone else) were discriminated against? Please be as specific as possible. (Attach additional pages as needed)

Please sign and date this complaint.

SIGNATURE _____ DATE / /

The remaining information on this form is optional. Failure to answer the question below will not affect this complaint in any way.

Do you need special accommodations for us to communicate with you about this complaint? (check all that apply)

Braille
 Large Print
 Cassette Tape
 Computer diskette
 Electronic mail
 TDD

Sign Language Interpreter (specify language): _____

Foreign Language Interpreter (specify language): _____
 Other: _____



If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME		LAST NAME
HOME PHONE () -		ALTERNATE PHONE () -
STREET ADDRESS		CITY
STATE	ZIP	E-MAIL ADDRESS (if available)

**If you have questions about this form, call the DFCS Civil Rights Program Office at:
404-657-3735**

