Georgia Department of Human Services

DHS-Office of Facilities & Supports Discrimination Complaint Form

The Georgia Department of Human Services (DHS) is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex (including gender identity and sexual orientation) and, in some cases, religion or political beliefs.

If you need assistance in completing this form or in communicating with us, ask us or call 404-657-5244 and leave a message. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

To file a complaint with the U.S. Department of Health and Human Services:

The U.S. Department of Health and Human Services (HHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

HHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  -Qualified sign language interpreters
  -Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  -Qualified interpreters
  -Information written in other languages

If you need these services, contact HHS at 1-877-696-6775.

If you believe that HHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

(1) mail: U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

(2) fax: (202) 619-3818; or

(3) email: OCRComplaint@hhs.gov

For any other information dealing with HHS issues, persons should either contact the HHS Number at (877) 696-6775, which is also in Spanish or visit their website at: https://www.hhs.gov/about/contact-us/index.html

DHS is an equal opportunity provider.

You may make a verbal or written complaint alleging unlawful discrimination by DHS (including if you disagree with decisions made regarding requests for reasonable modifications, auxiliary aids or services, or if you believe DHS failed to provide a requested reasonable modification or communication assistance under the ADA/Section 504), by completing the form below.

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

Program Manager
DHS LEP/SI Program
47 Trinity Ave SW
Atlanta, GA 30334
(404) 657-5244*
lepsi@dhs.ga.gov

***Constituents with a hearing or speech disability may call 711 for an operator to connect with us.**

If filing a complaint with DHS, please complete the form on the next page and return it to the above DHS address.

YOU HAVE A RIGHT TO FREE INTERPRETER SERVICES AND AUXILIARY AIDS AND SERVICES

County Office where violation occurred	Date the discrimination occurred	Sex or Gender Identity ☐ Male ☐ Female
First Name (Injured Party)	Last Name	Date of birth / /
Home Phone ( ) -	Home Phone ( ) -	
Street Address		City
State	Zip	Email address (if available)

Is this complaint being filled out for someone else? ☐ Yes ☐ No If "Yes," include your name below: First name: Last name: Contact information:	Do you wish to remain anonymous? (circle one) Yes No

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

- ☐ Race
- ☐ Color
- ☐ Sex, Gender Identity, or Sexual Orientation
- ☐ Age
- ☐ Religion
- ☐ Political Beliefs
- ☐ National Origin:
  - ☐ Limited English Proficient
- ☐ Disability:
  - ☐ Hearing Impairment
  - ☐ Vision Impairment
  - ☐ Speech Impairment
  - ☐ Failure to provide the requested Reasonable Modification (RM)
  - ☐ Failure to provide requested auxiliary aid or service (AAS)
  - ☐ Disagree with the ROM decision/modification provided
  - ☐ Other (service animals/mobility aids/design standards, etc.
  - ☐ Comments: _____

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
- ☐ Electronic mail
- ☐ TTY
- ☐ Sign Language Interpreter (specify language): _____
- ☐ Spoken Language Interpreter (specify language): _____
- ☐ Other:

If you have questions about this form, contact the DHS LEP/SI Office at Lepsi@dhs.ga.gov or call 404-657-5244