Appendix 5

State of Montana
Department of Public Health and Human Services

Complaint Resolution Form

Alternative accessible formats of this document are available on request.

Complainant's Name: _____(First)_____ (Middle)_____ (Last)

Mailing Address: _____ (Street)_____ (P.O. Box)
_____(City)_____ (ST)_____ (Zip Code)

Phone Number: _____ (Home)_____ (Work)_____ (Cell)

Complainant's Status:

☐ Employee ☐ Job Applicant ☐ Department Customer ☐ Interested Person

Basis of Complaint:

☐ Race ☐ Color ☐ Genetic Information ☐ Retaliation

☐ Creed ☐ Age ☐ National Origin ☐ Political Belief

☐ Religion ☐ Physical or Mental Disability ☐ Sexual Orientation

☐ Marital Status ☐ Sex ☐ Veteran Status ☐ Social Origin or Condition

☐ Ancestry ☐ Culture

Name of person you believe discriminated against you: _____

Department or Address: _____

Phone: _____

Date: _____ **Time:** _____ **Place of the incident(s):** _____

Documentation:
Please attach copies of any documents or material you believe are relevant.

Witnesses:
Did anyone witness the incident(s) of discrimination? ☐ Yes ☐ No If so, please list names and phone numbers of any witnesses to the incident(s). Use additional pages if necessary.

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Statement:
Please describe the incident(s) as clearly and concisely as possible. Provide as much detail as you can recall, including when and where the events occurred and who said what to whom. Explain why you believe the conduct or treatment was discriminatory. Use additional pages, if necessary.

Action Sought:
Please describe what you would like to see done to correct the situation.

Complaint Authorization:
I understand that complete confidentiality cannot be maintained in the process of handling informal and formal complaints. I agree that this statement of allegations may be used during the investigation of the case. I further consent that this statement and certain information in the complaint file may be disclosed to certain agency employees including the person I believe discriminated against me in order to resolve my complaint, conduct fact finding, or implement remedial action. I also understand that information may be disclosed if required by law, rule, regulation, or court order. I affirm that this complaint statement is true, accurate, and complete to the best of my knowledge.

_____ _____
Signature of Complainant **Date**

In addition to, or in lieu of, filing a complaint of unlawful discrimination or retaliation under this complaint process, individuals may file a complaint with an applicable state or federal agency. Jurisdiction may vary based on the nature of the complaint. For advice, assistance and an explanation of filing deadlines, individuals may contact the following:

Department of Public Health and Human Services (DPHHS)
Office of Human Resources
Civil Rights/EEO Specialist
P.O. Box 4210
Helena, MT 59604
Phone: (406) 444-1386
Fax: (406) 444-0262
V, TTY: (800) 833-8503
V, TTY: (406) 444-1335

Montana Human Rights Bureau (HRB)
33 S. Last Chance Gulch
P. O. Box 1728
Helena, MT 59624
Phone: (800) 542-0807
Phone: (406) 444-2884
Fax: (406) 444-2798
TTY: (406) 444-0532

Office for Civil Rights (OCR) U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, CO 80202
Voice Phone: (800) 368-1019
Fax: (303) 844-2025
TDD: (800) 537-7697

United States Equal Employment Opportunity Commission (EEOC)
Federal Office Building
909 First Avenue, Suite 400
Seattle, WA 98104-1061
Phone: (800) 669-4000
Fax: (206) 220-6911
TTY: (800) 669-6820