



DEPARTMENT OF  
PUBLIC HEALTH &  
HUMAN SERVICES

# 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:

- |                                   |  |   |   |
|-----------------------------------|--|---|---|
| <input type="checkbox"/> Race     | <input type="checkbox"/> Color                         | <input type="checkbox"/> Genetic Information        | <input type="checkbox"/> Retaliation      |
| <input type="checkbox"/> Creed    | <input type="checkbox"/> Age                           | <input type="checkbox"/> National Origin            | <input type="checkbox"/> Political Belief |
| <input type="checkbox"/> Religion | <input type="checkbox"/> Physical or Mental Disability | <input type="checkbox"/> Sexual Orientation         | <input type="checkbox"/> Marital Status   |
| <input type="checkbox"/> Sex      | <input type="checkbox"/> Veteran Status                | <input type="checkbox"/> Social Origin or Condition | <input type="checkbox"/> Ancestry         |
| <input type="checkbox"/> 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.

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**Signature of Complainant**

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**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  
Kirk Hindoen  
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

**Office for Civil Rights (OCR)**

1961 Stout Street, Room 08-148  
Denver, Colorado 80294  
Toll Free (800) 368-1019  
Phone: 303-844-7915  
Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)  
[Complaint portal](#)

**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

**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