**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