

**SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) CIVIL / HUMAN
RIGHTS VIOLATION COMPLAINT FORM**

Client Name: _____ SNAP Case No: _____

SSD Location/address: _____

Telephone: _____

Basis for complaint: _____

Date of Complaint: _____ Acknowledged (date): _____

File opened on (date) _____

If necessary, inactive period, from (date) _____ to (date) _____

Reason:

Written complaint and all documentation received (date) _____

SSD Investigation began (date) _____

Staff assigned: _____ Telephone: _____

Determination:

Complaint Unsubstantiated/Dismissed

Client notified _____

Date _____

Complaint Substantiated/Resolution Reached

Client notified _____

Date _____

Complaint Referred to NYS/OTDA EOD for Investigation:

Client notified _____ Date _____

Complaint referred _____ Date _____