LDSS-5065 (Rev. 5/15)

OFFICE OF TEMPORARY AND DISABILTY ASSISTANCE (OTDA)
SUPPLEMENTAL NUTRITION ASSITANCE PROGRAM (SNAP) CIVIL/HUMAN RIGHTS VIOLATION COMPLAINT FORM

PURPOSE: The purpose of this form is to assist you in filing a Supplemental Nutrition Assistant Program (SNAP) Civil/Human Rights Violation Complaint. For help filling out the form, you may call the telephone number listed at the top of the complaint form. You are not required to use the complaint form. You may write a letter instead. If you write a letter it must contain all of the information requested in the form and be signed by you or your authorized representative. Incomplete information will delay the processing of your complaint.

You may also send a complaint by FAX also listed at the top of the complaint form. We must have a signed copy of your complaint. Incomplete information or an unsigned form will delay the processing of your complaint.

FILING DEADLINE: A program discrimination complaint must be filed no later than 180 days from the date you knew or should have known of the alleged discrimination, unless the time for filing is extended by **OTDA.** Complaints sent by mail are considered filed on the date the complaint was signed, unless the date on the complaint letter differs by seven days or more from the postmark date, in which case the postmark date will be used as the filing date. Complaints sent by fax or e-mail will be considered filed on the day the complaint is faxed or e-mailed. Complaints filed after the 180 day deadline must include a "good cause" explanation for the delay. For example, you may have "good cause" if:

1. You could not reasonably have been expected to know of the discriminatory act within the 180 day period;
2. You were seriously ill or incapacitated;
3. The same complaint was filed with another Federal, State, or local agency and that agency failed to act on your complaint.

OTDA POLICY: Federal law and policy prohibit discrimination against you based on the following: race, color, national origin, religion, sex, disability, age, marital status, sexual orientation, family/parental status, income derived from a public assistance program, and political beliefs. (Not all Bases apply to all programs).

OFFICE OF TEMPORARY AND DISABILTY ASSISTANCE (OTDA)
SUPPLEMENTAL NUTRITION ASSITANCE PROGRAM (SNAP) CIVIL/HUMAN RIGHTS VIOLATION COMPLAINT FORM

Case No.: _____

TO: **State of New York Office of**
Temporary and Disability Assistance (OTDA)
Bureau of Equal Opportunity and Diversity (EOD)
40 North Pearl Street
Albany, New York 12243
Tel: (518)473-8555 Fax: (518)473-8590

Name: _____ DSS Location: _____

County: _____

On what basis do you beleive you were discriminated?

- ☐ RACE
- ☐ COLOR
- ☐ NATIONAL ORIGIN
- ☐ CREED/RELIGION
- ☐ AGE
- ☐ SEX/SEXUAL HARASSMENT
- ☐ MARITAL/FAMILY STATUS
- ☐ DISABILITY
- ☐ ARREST RECORD
- ☐ CRIMINAL CONVICTION
- ☐ GENDER IDENITY
- ☐ PREDISPOSING GENETIC CHARACTERISTICS
- ☐ SEXUAL ORIENTATION
- ☐ MILITARY STATUS
- ☐ DOMESTIC VIOLENCE VICTIM STATUS
- ☐ POLITICAL BELIEFS AND RETALIATION

1. Do you require assistance and/or accommodation?

2. When did the act of discrimination occur? Who was responsible for the discriminatory act(s)?

3. Please describe the events that are the basis of your complaint.

4. When did the event take place and/or last occurred?

5. Please list below any persons (witnesses, fellow employees, supervisors, or others) with direct knowledge of the actions:

   Name:
   Address:

   Telephone No.:

   Name:
   Address:

   Telephone No.:

   Name:
   Address:

   Telephone No.:

   Name:
   Address:

   Telephone No.:

6. Remedies. How would you like to see your complaint resolved?

Please sign and date this complaint form below.

Signature: _____ **Date:** _____

_____
Address

_____
Telephone # E-mail Preferred method of communication

Have you filed a complaint about the incident(s) with another Federal, State, Local and/or Court? ☐ Yes ☐ No

If yes with whom did you file?