

# SNAP CIVIL/HUMAN RIGHTS VIOLATION COMPLAINT FORM



Office of Temporary and Disability Assistance

**PURPOSE:** The purpose of this form is to assist you in filing a Supplemental Nutrition Assistant Program (SNAP) Civil/Human Rights Violation Complaint with the **Office of Temporary and Disability Assistance**. For help filling out the form, you may call the telephone number listed below. 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.

**USDA POLICY:** In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

**NEW YORK STATE POLICY:** New York State law and policy additionally prohibits discrimination in the administration of public accommodations on basis of gender identity, sexual orientation, military status and marital status.

TO: State of New York Office of  
Temporary and Disability Assistance (OTDA)  
SNAP Civil Rights Team (SCRT)  
Division of Legal Affairs  
40 North Pearl Street – 16C  
Albany, New York 12243  
  
Tel: (518)474-7693  
  
Email: [accessibility@otda.ny.gov](mailto:accessibility@otda.ny.gov)

Name: \_\_\_\_\_ DSS Location: \_\_\_\_\_

County: \_\_\_\_\_ SNAP Case No.: \_\_\_\_\_

I believe I was discriminated against because of my:

- RACE
- COLOR
- NATIONAL ORIGIN
- CREED/RELIGION
- AGE
- SEX
- DISABILITY
- POLITICAL BELIEFS
- PARTICIPATION IN A PRIOR DISCRIMINATION INVESTIGATION (REPRISAL/RETALIATION)
- GENDER IDENTITY\*
- SEXUAL ORIENTATION\*
- MILITARY STATUS\*
- MARITAL/FAMILY STATUS\*

\* Additional protections under New York State law and policy

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1. Does the complainant require assistance and/or special accommodations?

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

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

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

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

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7. 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? \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Preferred method of Communication: \_\_\_\_\_

Please sign and date this complaint form below.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*