

COMPLAINT OF DISCRIMINATORY TREATMENT

TO: San Francisco Human Services Agency
Office of Civil Rights (OCR)
City and County of San Francisco
P.O. Box 7988
San Francisco, CA 94120

SSN:

CASE NUMBER:

I, _____, hereby file this complaint of discriminatory treatment
(Please print your name) and request that an investigation be conducted.

I believe I was discriminated against because of my:

- NATIONAL ORIGIN (including language)
COLOR
RACE
ANCESTRY
ETHNIC GROUP IDENTIFICATION
PHYSICAL OR MENTAL DISABILITY
AGE
SEX
GENDER
GENDER IDENTITY OR EXPRESSION
SEXUAL ORIENTATION
MARITAL STATUS
DOMESTIC PARTNERSHIP
MEDICAL CONDITION
GENETIC INFORMATION
RELIGION
POLITICAL AFFILIATION
CITIZENSHIP
IMMIGRATION STATUS
ANY OTHER APPLICABLE BASIS:

DATE OF OCCURRENCE: _____

NAME(S) AND TITLE(S) OF THE PERSON(S) WHO I BELIEVE DISCRIMINATED AGAINST ME:

THE ACTION, DECISION OR CONDITION WHICH CAUSED ME TO FILE THIS COMPLAINT IS AS FOLLOWS:

I WISH TO HAVE THE FOLLOWING CORRECTIVE ACTION TAKEN:

CONSENT GRANTED - By initialing this option, I am authorizing the Human Services Agency (HSA), Office of Civil Rights (OCR) to reveal my identity and other personal information to persons at the organization or institution under investigation and to other Federal and State agencies in accordance with applicable federal and state laws and regulations. I hereby authorize HSA to receive material and information including, but not limited to applications, case files, personal records, and medical records. The material and information shall be used for authorized civil rights compliance and enforcement activities. I understand that I am not required to authorize this release and I do so voluntarily.

CONSENT DENIED - I do not give my consent for the release of my name or other personally identifying information. I understand that this complaint may not be investigated as a result of my refusal to give my consent for the release of information.

(SIGNATURE) (DATE) ADDRESS: _____