



## West Virginia Department of Health and Human Resources Civil Rights Discrimination Complaint Form

|  |                 |  |  |
|--|-----------------|--|--|
| <b>Complainant First Name</b>                |                 | <b>Complainant Last Name</b>                 |  |
| <b>Home Phone</b> <i>(include area code)</i> |                 | <b>Work Phone</b> <i>(include area code)</i> |  |
| <b>Street Address</b>                        |                 | <b>City</b>                                  |  |
| <b>State</b>                                 | <b>Zip Code</b> | <b>Email</b> <i>(if available)</i>           |  |

Is this complaint being completed by someone other than the complainant?  Yes  No

If yes, please provide your information below:

|                   |                  |  |
|-------------------|------------------|--|
| <b>First Name</b> | <b>Last Name</b> | <b>Telephone Number</b> <i>(include area code)</i> |
|-------------------|------------------|--|

The complainant feels they have been discriminated against on the basis of:

- Race/Color/National Origin   
  Religion/Creed   
  Sexual Orientation/Gender Identity  
 Disability   
  Age   
  Sex

Other *(please specify):*

Who or what bureau within the West Virginia Department of Health and Human Resources is believed to have been discriminatory?

|                           |                  |               |
|---------------------------|------------------|---------------|
| <b>Name/Bureau/Office</b> |                  |               |
| <b>Street Address</b>     | <b>City</b>      | <b>County</b> |
| <b>Zip Code</b>           | <b>Telephone</b> |               |

Date(s) discriminatory action is believed to have occurred:

Which program(s) is the complainant alleging the discriminatory action took place in?

- Child Welfare *(includes CPS, Youth Services, Foster Care, Adoption, Homefinding, and Legal Guardianship)*   
  Adult Welfare *(includes APS, Guardianship, Health Care Surrogate, Residential Services Request to Receive and Request to Provide)*   
  Low Income Energy Assistance Program (LIEAP)  
 Temporary Assistance for Needy Families (TANF)   
  School Clothing Voucher   
  Indigent Burial

*Complaints involving the Supplemental Nutrition Assistance Program (SNAP) must be sent directly to the U.S. Department of Agriculture. See below for more information.*

**Describe briefly what happened. How and why does the complainant believe they have been discriminated against? What is the relief or remedy sought by the complainant?**

*(Attach additional pages as needed.)*

Please sign and date this form. If submitting by email, you may type your name and date. Your email will represent your signature.

|                  |                          |
|------------------|--------------------------|
| <b>Signature</b> | <b>Date (mm/dd/yyyy)</b> |
|------------------|--------------------------|

The West Virginia Department of Health and Human Resources shall not retaliate against, intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Title VI, Section 504 or the Age Act, or because she or he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing.

EEO/Civil Rights Officer shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. EEO/Civil Rights Officer will maintain the files and records of DHHR relating to such grievances. The EEO/Civil Rights Officer shall issue a written decision on the complaint no later than thirty (30) calendar days after its filing, unless the Coordinator documents exigent circumstances requiring additional time to issue a decision. To submit this complaint or request additional information, please contact:

West Virginia Department of Health and Human Resources  
Office of Human Resource Management  
EEO/Civil Rights Officer  
(304) 558-3313 (voice)  
(304) 558-6051 (fax)  
[DHHRCivilRights@WV.Gov](mailto:DHHRCivilRights@WV.Gov) (email)

The person filing the grievance retains the right to file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, regardless of the decision made by the West Virginia Department of Health and Human Resources. The availability and use of this grievance procedure does not prevent a person from filing a private lawsuit in Federal court or a complaint of discrimination on the basis of being a member of a protected class, with the:

U.S. Department of Health & Human Services  
200 Independence Ave., S.W.  
Room 509F HHS Bldg.  
Washington, D.C. 20201  
800-368-1019 (voice)  
202-619-3818 (fax)  
800-537-7697 (TDD)  
[OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov) (email)

The complaint form may be found at <https://www.hhs.gov/ocr/complaints/index.html>

*For SNAP complaints, please contact the U.S. Department of Agriculture.*

*The USDA Program Discrimination Complaint Form, can be found online at: <https://www.ocio.usda.gov/document/ad-3027>, or at any USDA office. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form by mail, email, or fax to:*

*U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW Washington, D.C. 20250-9410  
(202) 690-7442 (fax)  
(866) 632-9992 (telephone)  
[program.intake@usda.gov](mailto:program.intake@usda.gov) (email)*