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| **DEPARTMENT OF HEALTH SERVICES**  Office of Legal Counsel  F-80983 (05/2019) | | | | | **STATE OF WISCONSIN**  42 USC §§ 18116, 2000d, 6101; 29 USC § 701;  7 USC § 2020; 20 USC § 1681; DHS AD 52.3, 36.4 | | | | |
| **CIVIL RIGHTS COMPLAINT** | | | | | | | | | |
| This civil rights complaint form is for members, applicants, enrollees, and beneficiaries of any Wisconsin Department of Health Services (DHS) program or activity for internal DHS investigations into allegations of discrimination on the basis of race, color, national origin, sex, age, disability and, in some cases, religious creed or political belief, and reprisals or retaliation, depending on the program. **Complaints of discrimination in employment or matters not involving DHS programs or activities will not be investigated by this office**.  Complaints about DHS services and benefits funded by the United States Department of Health and Human Services (HHS) (for example, Medicaid/BadgerCare) may also be filed with HHS. Complaints about the Supplemental Nutrition Assistance Program (SNAP)/FoodShare Wisconsin may be filed with the United States Department of Agriculture (USDA). Any complaint about Women, Infants, and Children (WIC), The Emergency Food Assistance Program (TEFAP), the Commodity Supplemental Food Program (CSFP), or other non-SNAP USDA program must be filed with the USDA. In most cases, complaints must be received within **180 days** of the alleged discriminatory act. For directions on completing this form, see the instructions at [www.dhs.wisconsin.gov/forms/f8/f80983a.pdf](https://www.dhs.wisconsin.gov/forms/f8/f80983a.pdf). | | | | | | | | | |
| **SECTION I – Who Was Discriminated or Retaliated Against?** | | | | | | | | | |
| Date Completed: | | | | | | | | | |
| First Name | | | | Middle Initial | | Last Name | | | | |
| Mailing Address – Street | | City | | | | Zip Code | | County | |
| Preferred Phone Number | | Other Phone Number | | | | Email Address | | | Fax |
| Complainant Authorized Legal Representative | | | | | | | | | |
| **SECTION II – What Person or Organization Do You Believe Discriminated or Retaliated Against You (or someone else)?** | | | | | | | | | |
| Name (Agency, Medical Assistance Provider, or Business) | | | | | Type of Agency, Medical Assistance Provider, or Business | | | | |
| Name – Person Responsible, if known | | | | | Organizational Title | | | | |
| Address | City | | | | | Zip Code | | County | |
| Phone Number – Include Area Code and Extension       , ext. | | | | | Email Address | | | | |
| **SECTION III – What Do You Allege is the Reason for Discrimination or Retaliation?** | | | | | | | | | |
| Of which DHS program (for example, BadgerCare Plus, Medicaid, SeniorCare, Supplemental Nutrition Assistance Program (SNAP)/FoodShare Wisconsin, Include, Respect, I Self-Direct (IRIS), Family Care, FoodShare Employment and Training (FSET), Refugee Health Program) are you a member, applicant, enrollee, or beneficiary      ? | | | | | | | | | |
| Which of the following do you allege was the reason for the discrimination/retaliation? Check the box that you allege is the reason complainant (identified in Section I) was discriminated/retaliated against. | | | | | | | | | |
| Race | | | Color | | | | National Origin or Limited English Proficiency  Preferred Language: | | |
| Sex/Gender/Sexual Orientation | | | Age | | | |
| Disability | | | Religion/Creed | | | |
| Political Affiliation | | | Retaliation/Reprisal | | | |
| Date the last incident of discrimination occurred: | | | | | | | | | |

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| **SECTION IV – What Discriminatory or Retaliatory Action Happened to You?** | |
| Use additional pages, as is necessary, to fully complete this section.   1. Describe the events that make you believe you were discriminated against in receiving benefits, services or access to a DHS program. 2. Give the date each action occurred and name of the person who took the action. 3. Explain why you believe the action was because of the box(es) you checked in Section III. | |
| **SECTION V – Submit Your Complaint** | |
| **Mail or email:**  Department of Health Services  Civil Rights Compliance  1 West Wilson Street, Room 651  PO Box 7850  Madison, WI 53707-7850 | 608-267-4955 (Voice), 608-267-1434 (Fax)  711 or 1-800-947-3529 (TTY)  Email: [DHSCRC@dhs.wisconsin.gov](mailto:DHSCRC@dhs.wisconsin.gov) |
| **If you need language assistance or an accommodation to prepare this complaint, please contact us.**  **If you have questions regarding the terms and words used in this form, or need other assistance filling out this form, please contact us.** | |

Nondiscrimination Notice: Discrimination is Against the Law – Health Care-Related Programs

The Wisconsin Department of Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Department of Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Department of Health Services:

* Provides free aids and services to people with disabilities to communicate effectively with us, such as:
* Qualified sign language interpreters.
* Written information in other formats (large print, audio, accessible electronic formats, other formats).
* Provides free language services to people whose primary language is not English, such as:
* Qualified interpreters.
* Information written in other languages.

If you need these services, contact the Department of Health Services civil rights coordinator at 844‑201-6870.

If you believe that the Department of Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Department of Health Services, Attn: Civil Rights Coordinator, 1 West Wilson Street, Room 651, PO Box 7850, Madison, WI 53707-7850, 844-201-6870, TTY: 711, fax: 608-267-1434, or email to [dhscrc@dhs.wisconsin.gov](mailto:dhscrc@dhs.wisconsin.gov). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Department of Health Services civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201   
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

