County of Riverside Department of Public Social Services

# CIVIL RIGHTS DISCRIMINATION COMPLAINT

California's county welfare departments may not discriminate against an individual, or a group, on the basis of race, color, ancestry, national origin *(including language)*, ethnic group identification, age, physical or mental disability, medical condition, religion, sex, gender, gender identity or expression, sexual orientation, marital status, domestic partnership, political affiliation, citizenship, immigration status, or genetic information when determining/providing aid, benefits, or services.

**Complete this form to report a discrimination complaint.** (*Customers should complete the form whenever possible. Otherwise, DPSS staff should complete the form on the customer's behalf*.)

**PLEASE PRINT**

| CUSTOMER'S NAME: | | | AID TYPE: |
|---|---|---|---|
| STREET ADDRESS: Apt.#, Suite | | | CASE NUMBER: |
| CITY | STATE | ZIP CODE | PHONE NUMBER: |

Tell us what occurred:

| DATE OF OCCURRENCE: | OFFICE LOCATION: | NAME OF PERSON(S) INVOLVED IN THE OCCURRENCE: |
|---|---|---|
| | | |

I believe I have been discriminated against on the basis of: (*Check ALL the boxes that apply*.)

- ☐ RACE
- ☐ NATIONAL ORIGIN (*Including Language)*
- ☐ PHYSICAL OR MENTAL DISABILITY
- ☐ SEX
- ☐ SEXUAL ORIENTATION
- ☐ POLITICAL AFFILIATION
- ☐ GENETIC INFORMATION
- ☐ COLOR
- ☐ ETHNIC GROUP IDENTIFICATION
- ☐ MEDICAL CONDITION
- ☐ GENDER
- ☐ MARITAL STATUS
- ☐ CITIZENSHIP
- ☐ ANCESTRY
- ☐ AGE
- ☐ RELIGION
- ☐ GENDER IDENTITY OR EXPRESSION
- ☐ DOMESTIC PARTNERSHIP
- ☐ IMMIGRATION STATUS

Describe in your own words what action(s) have happened to you to lead you to believe you have been discriminated against:

______________________________

______________________________

______________________________

What resolution is being requested:

______________________________

______________________________

**Form completed by:**

☐ Customer

☐ DPSS staff: ______________________ ______________________

NAME (Print) PHONE NUMBER

☐ Other: ______________________ ______________________

NAME (Print) PHONE NUMBER

**The above information is true and complete to the best of my knowledge and belief.**

______________________________ ______________________

SIGNATURE OF PERSON COMPLETING THE FORM DATE

**Give completed form to any DPSS employee, or mail form to:**

DPSS Assurance & Review Services
731 Palmyrita Ave.Riverside, CA 92508
Attention: Civil Rights Coordinator

**(Upon receipt, the Civil Rights Coordinator/designee will contact you.)**