Community Resources for Independence DISCRIMINATION COMPLAINT FORM

Instructions: Any person who believes she or he has been subject to discrimination prohibited by Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, Section 504 of the Vocational Rehabilitation Act of 1973, and the Civil Rights Restoration Act of 1987, as amended, may file a complaint with CRI.

If you believe you have been discriminated against in services by CRI based on a class protected by public policy, please complete this form and submit it to Community Resources for Independence at the address provided below. If information is needed in another language, then contact 800-530-5541. Si necesita mas infomacion en otro lenguaje porfavor de llamar al 800-560-5541.

Section I:						
Name:						
Address:						
Telephone (Home):		Telephon	Telephone (Work):			
Electronic Mail Address:						
Accessible Format Requirements?	Large Print		Audio Tape	•		
	TDD		Other			
Section II:						
Are you filing this complaint on your own behalf?			Yes*	No		
*If you answered "yes" to this question, go to Section III.						
If not, please supply the name and relationship of the person for whom you are complaining:						
Please explain why you have filed for a third party:						
Please confirm that you have obtained the permission of the			Yes	No		
aggrieved party if you are filin	ng on behalf of a third par	ty.				
Section III:						
I believe the discrimination I experienced was based on (check all that apply):						
[] Race (Title VI) [] Color (Title VI) [] National Origin (Title VI) [] Ancestry [] Religious Creed						
[] Disability (ADA) [] Gende	r [] Sexual Prefei	ence	[] Age [] Vete	eran status		
[] Other criteria prohibited by public policy (specify):						
Date of Alleged Discrimination (Month, Day, Year):						
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please use the back of this form.						
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Section IV						
Have you previously filed a discrimination comp other) with this agency?	laint (Title VI, ADA,	Yes	No			
Section V						
Have you filed this complaint with any other Fec court?	leral, State, or local a	gency, or with an	y Federal or State			
[]Yes []No						
If yes, check all that apply:						
[] Federal Agency:	-					
[] Federal Court	[] State Agency					
[] State Court	[] Local Ager	ncy				
Please provide information about a contact person at the agency/court where the complaint was filed.						
Name:						
Title:						
Agency:						
Address:						
Telephone:						
Section VI						
Name of agency complaint is against:						
Contact person:						
Title:						
Telephone number:						

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date required below

Signature

Date

Printed Name

Telephone Number

Street Address

City, State, ZIP

Please submit this form in person at the address below, or mail this form to: Community Resources for Independence; Attn: Director; 3410 West 12th Street; Erie PA 16505