COMPLAINT UNDER AMERICANS WITH DISABILITIES ACT
(Title II) and Section 504

Michigan Department of Human Services

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 2.

Complainant Name:

Address:		
City	State	Zip Code
Telephone: Home: ( ) Business: ( )		

Person Completing This Form: (if other than the complainant)		
Address:		
City	State	Zip Code
Telephone: Home: ( ) Business: ( )		

County/Program that you believe has discriminated against you:

Name:

Address:		
County:		
City	State	Zip Code
Telephone Number: ( )		
When did the event occur? Date:		

Describe the event providing the name(s) where possible for the individuals who were involved (use space on page 2 if necessary):

Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other federal agency or court? Yes ☐ No ☐		
If yes give name of agency or court:		
Contact Person:		
Address:		
City	State	Zip Code
Telephone Number: ( )		
Date Filed:		

Do you intend to file with another agency or court? Yes ☐ No ☐		
Agency or Court:		
Address:		
City	State	Zip Code
Telephone Number: ( )		

Additional space for answers:

Signature:	Date

Return to:

Office of Human Resources
PO Box 30037
Lansing, MI 48909
Phone: (517) 335-3521
Fax: (517) 335-4673

Authority: Sec.709(c), Title VII, Civil Rights Act of 1969, as amended. **Response:** Voluntary **Penalty:** None	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.