STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

CIVIL RIGHTS COMPLAINT

REPORTING DISCRIMINATION ON AGE, RACE, COLOR, SEX, HANDICAP, RELIGIOUS CREED, OR NATIONAL ORIGIN.
Under Title VI Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Age Discrimination Act of 1975, Food Stamp Act of 1977 and American with Disabilities Act 1990

1. Name: First Middle Initial Last

2. Mailing Address Street or P.O. Box City State Zip Code

3. Telephone Number 4. Program (Please Circle)
ATAP SNAP Medicaid APA GRA/GRM

5. Name and Address of Office Against Which Complaint is Filed:

6. Describe the Nature of the Complaint in Detail:

NOTICE: The time limitation for filing a complaint is 180 days from the date of the alleged discriminatory act(s). Complaints which are older than 180 days should be forwarded directly to Civil Rights Coordinator, Division of Public Assistance, P.O. Box 110640, Juneau, AK 99811-0640.

7. How do you feel this complaint should be resolved?

8. I would be willing to meet with the responsible program officials or the Department Civil Rights Coordinator, to try to resolve my complaint. YES [ ] NO [ ]

Signature Date

GEN 101 (06-3787) Rev 07/10
Instructions: Administrative Procedures Manual 100-4

Distribution: 1. DPA, Civil Rights Coordinator
2. Complainant
3. District Office Civil Rights Complainant File