



# CIVIL RIGHTS COMPLAINT FORM

Family Advocates is a subrecipient of federal funds through the Idaho Council on Domestic Violence and Victim Assistance (ICDVVA), which is under the Idaho Department of Health and Welfare (DHW). ICDVVA is a recipient of federal funds under the U.S. Department of Justice and the U.S. Department of Health and Human Services. As a recipient of these funds, Family Advocates must comply with statutes and regulations which collectively prohibit discrimination based on race, color, national origin, sex, religion, disability, and age.

***Please complete by typing in the shaded areas.***

Date/Place (Street Address) discriminatory act took place:

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Names and Titles of Program and/or employee(s) involved:

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Names, Addresses and Telephone Numbers of Witnesses:

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Reason for the Alleged Discrimination:

Age                       Color                       Disability                       Sex  
 National Origin                       Race                       Religion                       Political Beliefs

Does your charge of discrimination involve?

Your job or seeking employment      **or**       Seeking/receiving services

Which of the following applies?

<input type="checkbox"/> Hiring	<input type="checkbox"/> Brutality
<input type="checkbox"/> Work Assignment	<input type="checkbox"/> Harassment
<input type="checkbox"/> Promotion	<input type="checkbox"/> Language
<input type="checkbox"/> Demotion	<input type="checkbox"/> Applying rules/laws differently
<input type="checkbox"/> Discipline	<input type="checkbox"/> Access to buildings/programs
<input type="checkbox"/> Layoff/Recall	<input type="checkbox"/> Retaliation
<input type="checkbox"/> Retaliation	<input type="checkbox"/> Segregation
<input type="checkbox"/> Termination	<input type="checkbox"/> Standards/opportunities/programs
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Other (Specify) _____

Please describe what happened:

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Why do you believe this occurred?

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If this complaint is resolved to your satisfaction, what remedy do you seek?

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Name of Person Lodging Complaint: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Signature

Date

**SUBMIT COMPLAINT FAMILY ADVOCATES TO:**

HUMAN RESOURCES  
3010 W.State St., Boise, ID 83703

or

HR@familyadvocates.org

**NONDISCRIMINATION  
COMPLIANCE AGENCIES**

U. S. Department of Justice  
Office of Justice Programs  
Office For Civil Rights  
810 Seventh Street, NW  
Washington, DC 20531  
202) 514-4609 (voice)  
(202) 514-0716 (TTY)

HHS Director  
Office for Civil Rights  
Room 515-F  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0403 (voice)  
(800) 537-7697 (TTY)

**COVERED PROGRAMS**

VOCA Victim Assistance Formula Grant

Family Violence Prevention & Services State  
Grant (FVPSA)