



## WIOA Discrimination Complaint Form

You have the right to receive fair treatment in programs and services funded by the Workforce Innovation Opportunity Act (WIOA) which is a federal program. You have a right to file a complaint when you feel that you were treated unfairly because of something about you, such as your race, color, religion, disability, sex, etc. **Please read the form carefully. Type or print your answers** in blue or black ink. Answer each question as completely as possible. If you cannot fit your whole answer in the space on this form, you may add more pages.

**If a question or field has a star next to it, you must answer that question.** You do not have to answer the other questions, but if you do, it will help us to process your complaint. If you do not know the answer to a question, put "not known" in the space for the answer. If the question does not apply to your case, put "n/a."

**\*1. Are you the complainant or a representative of the complainant? Please check the correct box.**

\_\_\_\_\_ Complainant      \_\_\_\_\_ Representative of the Complainant

**\*2. Please give your name and the other information we ask you for on the lines below. If you are a representative, please give the complainant's name and contact information in this section, and your own name and contact information in section 2A.**

\_\_\_\_\_   
 Complainant's Name

\_\_\_\_\_   
 Telephone Number where we can reach you

\_\_\_\_\_   
 Street Address

\_\_\_\_\_   
 City

\_\_\_\_\_   
 State

\_\_\_\_\_   
 Zip code

\_\_\_\_\_   
 Email Address

\_\_\_\_\_   
 Best Time to Contact You

\_\_\_\_\_   
 Name and contact information for someone we can contact if we cannot get in touch with you

**2A. If you are the complainant's representative, please give your name and contact information in this section, and attach a letter or other document signed by the complainant, authorizing you to serve as their representative.**

\_\_\_\_\_   
 Representative's Name

\_\_\_\_\_   
 Representative's Organization (if any)

\_\_\_\_\_   
 Street Address

\_\_\_\_\_   
 City

\_\_\_\_\_   
 State

\_\_\_\_\_   
 Zip code

\_\_\_\_\_   
 Telephone number(s) where we can reach you. (Do not give your work number if you don't want us to call you there.)

\_\_\_\_\_   
 Email Address(es)

\_\_\_\_\_   
 Best Time to Contact You

For the rest of the questions on this form, if you are filing this complaint on behalf of someone else, "you" means the person (the complainant), not you personally. Please give the answers the complainant would give.

**\*3. This complaint is about something that happened to (please check the appropriate response):**

\_\_\_\_\_ Only me                      \_\_\_\_\_ Me and other people                      \_\_\_\_\_ Other people, but not me

**\*4. Please give the name of the agency, organization, or business that you are complaining about. If you have any contact information for the agency, organization, or business, and/or if you know the name of the person(s) who you think discriminated against you, please give that information as well.** If you need more space to give all of the information, please attach more pages to this form.

\_\_\_\_\_  
\*Name of Agency, Organization, or Business

\_\_\_\_\_  
Street or Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip code

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Name of Person You Think Discriminated

\_\_\_\_\_  
Job Title

**\*5. What program was involved in the discrimination you are complaining about? If the program is not listed below, add it next to the "Other" option. If you do not know the name of the program, check "Do not know".**

\_\_\_\_ Workforce Innovation and Opportunity Act (WIOA) Program

\_\_\_\_ HireAbility (Vocational Rehabilitation)

\_\_\_\_ Wagner-Peyser Employment Service

\_\_\_\_ Job Center (Department of Labor)

\_\_\_\_ YouthBuild

\_\_\_\_ Unemployment Insurance

\_\_\_\_ JobCorps

\_\_\_\_ Indian/Native American Program

\_\_\_\_ Migrant and Seasonal Farm Workers Program

\_\_\_\_ Dislocated Worker Program

\_\_\_\_ Training Provider (which?) \_\_\_\_\_

\_\_\_\_ Other (what?) \_\_\_\_\_

\_\_\_\_ Do not know

**\*6. On what date(s) did the alleged discrimination take place?**

\_\_\_\_\_  
Date of the First Action

\_\_\_\_\_  
Date of the Most Recent Action

**\*7. What do you think was the basis (reason) for the alleged discrimination?** Please check the boxes next to all of the bases (reasons) you think were involved in the discrimination, and answer any other questions that go along with that box. In the next question, you will be asked to explain why you checked each box.

**Because of my National Origin.**

Are you Hispanic or Latino?  Yes  No

What is your national origin (the country from which you, your parents, your grandparents, or your earlier ancestors came)? \_\_\_\_\_

**Because of my Limited English Proficiency.**

What is the language in which you feel most comfortable communicating? \_\_\_\_\_

**Because of my Race.** What is your race? Please check all that apply.

White or Caucasian  Black or African American  Asian  
 American Indian or Alaska Native  Native Hawaiian or Pacific Islander  Other \_\_\_\_\_

**Because of my Disability.** Please check one of the following:

I have a disability (which may be active or inactive right now). What is your disability? \_\_\_\_\_

I have a record of a disability. What was your past disability? \_\_\_\_\_

I do not have a disability, but the organization or program treats me as if I have a disability.

**Because of my Sex.** What is your sex? \_\_\_\_\_

**Because of my Pregnancy.**

**Because of my Sexual Orientation.** What is your sexual orientation? \_\_\_\_\_

**Because of my Gender Identity.** What is your gender identity? \_\_\_\_\_

**Because of my Color.** What is your color? \_\_\_\_\_

**Because of my Religion.** What is your religion? \_\_\_\_\_

**Because of my Age.** What is your date of birth? \_\_\_\_\_

**Because of my Political Affiliation or Political Belief.**

What is your political affiliation or political belief? \_\_\_\_\_

**Because of my Citizenship.** What is your citizenship? \_\_\_\_\_

**Because of my participation in a program that receives Federal financial assistance.**

Name the program: \_\_\_\_\_

**I was retaliated against (Retaliation)** because I complained about discrimination, or because I gave a statement or was involved in some other way with someone else's discrimination complaint.

**\*8. For each of the bases (reasons for discrimination) you checked above, please explain what happened, how you were (or someone else was) harmed by what happened, and how or why you think what happened was because of the basis you checked.** For example, if you checked “Because of my Race,” list the facts you think explain *how or why* you think what happened was because of the race of the persons who were harmed. *If you do not explain why you checked a particular basis, we may reject that part of your complaint.*

If other persons or groups were treated differently from you (or the other people who you think were discriminated against), please describe who was treated differently, how their treatment was different, and how the different treatment harmed you (or the other people you think were discriminated against). Please be specific and brief. Give the name(s) of and contact information for any of the people involved, if you can.

If your answer does not fit in the space below, please use more pages of paper to finish your answer, and attach those pages to this form.

**9. Please list below any other people (witnesses, coworkers, supervisors, or others) whom you have not already named and whom we should contact for information about your complaint.** Attach additional pages if you need more space for this information.

Person's Name	Relationship to case (witness, coworker, etc.)	Best Time to Contact
Telephone number(s)	Email address(es)	

**10. What remedies are you asking for? For example, getting benefits or training you did not receive, changes in policies, etc.**

**11. Have you filed a written complaint with anyone else, such as the federal Equal Employment Opportunity Commission (EEOC), U.S. Department of Labor's Civil Rights Center (CRC), Vermont Attorney General, or the Vermont Human Rights Commission about the same events or actions you describe on this complaint information form?**

\_\_\_\_\_ Yes I have filed another written complaint.      \_\_\_\_\_ No I have not.

If yes, please answer these questions, as best you can, about *each* agency, department, organization, or business where you filed a written complaint (using additional pages if necessary):

Name of Office, Agency, Department, Organization, or Business	Date Filed		
Street of Mailing Address	City	State	Zip code
Telephone Number(s)	Email Address		
Name of Person Working on Your Complaint	Job Title	Telephone Number	

**11B. Has the place where you filed your first written complaint given you a final decision about the complaint?**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

**11C. If yes, what was the date of the final decision?** \_\_\_\_\_

Was the decision in writing? \_\_\_\_\_ Yes      \_\_\_\_\_ No

Include copies of written decisions, dismissals, or Right to Sue Letters, or other written responses to your complaint that you have received.

**\*12. Please sign and date this form in the space below that applies to you. Your signature certifies that the information you included in this form is true and accurate to the best of your knowledge. It also authorizes the State EO Officer to investigate your complaint and share the information on the form with others who are involved in the investigation. Your identity will be kept confidential to the maximum extent possible, consistent with applicable law and a fair determination of your complaint. We cannot accept a complaint for investigation unless this Complaint Form has been signed.**

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Complainant's Representative

\_\_\_\_\_  
Date

**Please mail, email, or hand deliver your signed complaint to one of the following:**

1. The **Complaint Representative** at your local Vermont Department of Labor (VDOL) office
  
2. **Michael A. Harrington, Commissioner**  
State-Level Equal Opportunity Officer  
Vermont Department of Labor  
P.O. Box 488 Montpelier, VT 05601-0488  
802-828-4301 Telecommunications Relay: 711
  
3. **Jay Ramsey, Director of Workforce Development**  
Recipient Level Equal Opportunity Officer  
Vermont Department of Labor  
P.O. Box 488 Montpelier, VT 05601-0488  
802-828-4343 Telecommunications Relay: 711
  
4. labor.eoofficer@vermont.gov

Persons are not required to provide personal private data. Completing this form is voluntary; however, answers to the starred questions and fields must be provided in order for VDOL to accept your discrimination complaint. VDOL will use the information to process, and where appropriate to investigate, your complaint. The estimated average time to complete this form is 60 minutes.

***The Vermont Department of Labor is an equal opportunity employer that administers equal opportunity programs. Auxiliary aids and services are available upon request to individuals with disabilities. Free language access assistance is also available. Send an email to labor.eoofficer@vermont.gov or call us at 802-828-4000 (Telecommunications Relay 711) if you are in need of these services.***