MISSISSIPPI STATE DEPARTMENT OF HEALTH

CIVIL RIGHTS COMPLAINT FORM

This form is to be utilized when filing a complaint of a violation of civil rights laws or non-discrimination provisions. This form is to be used by patients, clients, consumers, program participants filing a complaint alleging discrimination from a Mississippi State Department of Health (MSDH) program or subgrant recipient funded by MSDH.

Continue any answer to a question on additional sheets if necessary. Attach any written materials or documentation pertaining to your case.

Your name, address, telephone number(s) and email address:

Do you have a representative? Yes☐ No☐

If so, please list the representatives first name, last name and mailing address, telephone number(s) and email address:

Name, address, and telephone number(s) of person(s) who discriminated against you:

Name, address and telephone number(s) of agency or organization involved in your complaint:

Are there other persons or organizations involved in this discrimination case? Yes☐ No☐
If YES, please give the names, addresses and telephone numbers below:

NAME	ADDRESS	TELEPHONE

Which of the following describes the nature of the discrimination involved?

Race ☐ Color ☐ National Origin ☐ Sex ☐ Sexual Orientation ☐ Disability ☐

Gender Identity ☐ Gender Expression ☐ Age ☐ Retaliation or Reprisal ☐

Where did the discrimination occur?

Which month(s), day(s), and year(s) did the most recent discrimination against you take place?

Beginning: Month____ Day____ Year_____

Ending: Month____ Day____ Year_____

Explain in detail what happened to you.

Please list below any persons whom we might contact for additional information to support or clarify your complaint:

NAME	ADDRESS	TELEPHONE

Please provide any other information, including supporting documentation, that might be helpful to our investigation.

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

Have you filed your Complaint with any of the following? (Check the appropriate items.)

☐ Civil Rights Division, U.S. Dept. Of Justice ☐ U.S. Equal Employment Opportunity Commission

☐ Other Federal Agency ☐ Federal or State Court

☐ Attorney ☐ Other (specify)_____

☐ Health and Human Services-OCR

For any item checked above, please provide the following information:

Name of Agency/Individual: _____

Date Filed: _____

Case or Docket Number: _____

Date of Trial or Hearing:_____

Location of Agency or court: _____

Name of Investigator_____

Status of Case: _____

Additional comments:

Supporting Documentation Attached (Check one): Yes☐ No☐

DATE: _____ SIGNED: _____

Please submit this Civil Rights Complaint Form to the Mississippi State Department of Health by mail or email at:

Charles Lee, Civil Rights Coordinator
Mississippi State Department of Health
P.O. Box 1700
Jackson, Mississippi
39215-1700
Telephone: 601-576-7847
Email: civilrights@msdh.ms.gov

The availability and use of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of race, color, national origin, sex, age, disability, or retaliation/reprisal with the applicable federal funding entity.

The complaint may be filed directly with the **U.S. Department of Health and Human Services** using the information below:

File a Complaint Using the Civil Rights Discrimination Complaint Form Package
Open this link to fill out the Civil Rights Discrimination Complaint Form Package in PDF format. You will need Adobe Reader software to fill out the complaint and consent forms.

You may either:
Print and mail the completed complaint and consent forms to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201, or

Email the completed complaint and consent forms to OCRComplaint@hhs.gov (Please note that communication by unencrypted email presents a risk that personally identifiable information contained in such an email, may be intercepted by unauthorized third parties)

File a complaint using the HHS OCR Online Portal
Open and follow this link to use the U. S. Department of Health & Human Service Complaint Portal: OCR Online Portal

This complaint may also be filed directly with the **U.S. Department of Justice, Civil Rights Division,** electronically through their portal, at https://civilrights.justice.gov/report/ or by mail or phone at:

U.S. Department of Justice, Civil Rights Division
950 Pennsylvania Ave, NW
Washington, D.C. 2530-0001
Toll-free: 1-855-856-1247
TTY: 202-514-0716

If you are filing a complaint related to the **Women, Infants and Children's Nutrition Program (WIC)**, you may choose to file the complaint directly with the **USDA** electronically at U.S. Department of Agriculture USDA Program Discrimination Complaint Form (Spanish – Español): https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf) or by mail or phone at:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
Facsimile: (833) 256-1665 or (202) 690-7442
Email: Program.Intake@usda.gov

USDA Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

ATTENTION: If you have difficulty understanding English or have a disability, free language assistance or other aids and services are available. MSDH provides free interpretation services, translation of materials, or other assistance available upon request: call 601-206-1720.

Español (Spanish) | Si tiene dificultades para entender inglés o tiene una discapacidad, háganoslo saber. La asistencia lingüística gratuita u otros servicios de ayuda están disponibles a pedido en su departamento de salud local sin cargo. Llame al 601-206-1720.

Tiếng Việt (Vietnamese) | Nếu quý vị gặp khó khăn trong việc hiểu tiếng Anh hoặc bị khuyết tật, vui lòng cho chúng tôi biết. Hỗ trợ ngôn ngữ miễn phí hoặc các dịch vụ trợ giúp khác được cung cấp miễn phí theo yêu cầu tại Sở Y Tế địa phương của quý vị: 601-206-1720.

中文 (Chinese) | 如果您在理解英語方面有困難或有殘疾，請告知我們。當地衛生部門可應要求免費提供語言協助或其他援助服務。601-206-1720.

اللغة العربى (Arabic) | إذا كنت تواجه صعوبة في فهم اللغة الإنجليزية أو تعاني من إعاقة، فيرجى إخبارنا بذلك. إذ تتوفر المساعدة اللغوية مجانًا أو خدمات المساعدة الأخرى مجانًا عند طلبها من الإدارة المحلية للشؤون الصحية: 601-206-1720.

Français (French) | Si vous éprouvez de la difficulté à comprendre l'anglais ou si vous souffrez d'un handicap, veuillez nous en informer. Une assistance linguistique gratuite et d'autres services d'aide sont disponibles sur demande auprès de votre service de santé local. Veuillez appeler: 601-206-1720.

Kreyol (Haitian) | Si w gen difikilte pou w konprann Angle oswa si w gen yon andikap, tanpri fè nou konnen. Asistans lang gratis oswa lòt sèvis èd disponib sou demann nan Depatman Sante lokal ou a gratis. Tanpri rele: 601-206-1720.

Italiano (Italian) | Se non capisce bene l'inglese o ha una disabilità, ce lo comunichi. Presso il locale Dipartimento della salute sono disponibili a titolo gratuito un servizio di assistenza linguistica o altri servizi di assistenza su richiesta. Contattare: 601-206-1720.

Deutsch (German) | Wenn Sie kein Englisch verstehen oder eine Behinderung haben, teilen Sie es uns bitte mit. Kostenlose Sprachunterstützung oder andere Hilfsdienste sind auf Wunsch bei Ihrem lokalen Gesundheitsamt kostenlos verfügbar: 601-206-1720.

Hindi | यदि आपको अंग्रेजी समझने में कठिनाई होती है या आप अक्षम हैं, तो अनुरोध करने पर मुफ्त भाषा सहायता या अन्य मदद और सेवाएं उपलब्ध हैं। कृपया कॉल करें: 601-206-1720.

فارس ی (Farsi)
اگر زبان انگلیسی را درک نمیکنید یا دارای معلولیت هستید، لطفاً به ما اطلاع دهید. خدمات رایگان زبانی یا سایر خدمات امدادی، در صورت نیاز به صورت رایگان در اداره بهداشت محلی شما قابل دریافت است : 601-206-1720.

한국어 (Korean) |영어를 이해하는 데 어려움이 있거나, 장애가 있는 경우 저희에게 알려주십시오. 무료 언어 지원 또는 기타 지원 서비스는 요청 시 지역 보건부에서 무료로 제공됩니다: 601-206-1720.

Yoruba |Tí o bá ní ìṣòro mípa òye Gẹ̀ẹ́sì tàbí o ní àìlera, jọ̀wọ́ jẹ́ kí a mọ̀. Àǹfàní ètò ìrànlọ́wọ́ èdè àti àwọn ètò ìrànlọ́wọ́ mìíràn wà tí o bá bèèrè fun ní ẹ̀ka Ìtọ́jú ìlera àdùúgbò lọ́fẹ̀ẹ́: 601-206-1720.

Igbo
Ọ bụrụ na ọ na-esiri gị ike ịghọta Bekee ma ọ bụ na i nwere nkwarụ, biko mee ka anyị mara. Enyemaka asụsụ efu ma ọ bụ ọrụ enyemaka ndị ọzọ dị mgbe a chọrọ ha na Ngalaba Mpaghara Ahụike gị n'efu: 601-206-1720.