South Carolina Department of Health and Human Services (SCDHHS)
Office of Civil Rights & Privacy
CIVIL RIGHTS DISCRIMINATION COMPLAINT

Case Number _____

If you have questions about this form, call SCDHHS at (888) 808-4238/TTY (888) 842-3620. Return the completed form to: Office of Civil Rights & Privacy, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206

Your Name (First, Middle, Last)	Your Email Address (if available)		
Your Home Phone	Your Work Phone		
Street Address	City	State	ZIP

Are you filing this complaint on behalf of someone else? ☐ Yes ☐ No

If "Yes," whose civil rights do you believe were violated?

Name (First, Middle, Last)

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race/Color/National Origin ☐ Disability ☐ Age ☐ Religion ☐ Sex ☐ Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

Person/Agency or Organization	Phone		
Street Address	City	State	ZIP

When do you believe the civil rights discrimination occurred? List date(s):

Primary Type of Disability (pick one): ☐ Mobility ☐ Mental/Psychiatric ☐ Learning ☐ Vision ☐ Cognitive/Intellectual/Developmental ☐ Hearing ☐ Limited English Proficiency ☐ Speech ☐ Other

Issue (pick one): ☐ Physical Access ☐ Interpreter/Assistive Listening ☐ Service Animal ☐ Retaliation ☐ Denial of Services/Refusal to Admit ☐ Other or Don't Know

Describe briefly what happened. How and why do you believe your (or someone else's) civil rights were violated? Please be as specific as possible. (Attach additional pages as needed.)

Please sign and date this complaint	
Signature	Date

Filing a complaint with SCDHHS is voluntary. However, without the information requested above, SCDHHS may be unable to proceed with your complaint. We collect this information under the authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. You are not required to use this form. You may also write a letter that includes all information requested on this form.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html