



DISCRIMINATION COMPLAINT FORM

The purpose of this form is to assist you in filing a discrimination complaint with the New York State Division of Criminal Justice Services. You are not required to use this form; a letter with the same information is sufficient.

1. State your name and address.

Name: \_\_\_\_\_

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

Zip: \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

2. Person(s) discriminated against, if different from above:

Name: \_\_\_\_\_

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

Zip \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

Please explain your relationship to this person(s).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Agency and department or program that discriminated:

Name: \_\_\_\_\_

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

Zip \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

4A. Non-employment: Does your complaint concern discrimination in the delivery of services or in other discriminatory actions of the department or agency in its treatment of you or others? If so, please indicate below the base(s), actual or perceived, on which you believe these discriminatory actions were taken.

Race/Color: \_\_\_\_\_

National origin: \_\_\_\_\_

Sex: \_\_\_\_\_

Religion: \_\_\_\_\_

Age: \_\_\_\_\_

Disability: \_\_\_\_\_

Sexual Orientation \_\_\_\_\_

Gender Identity \_\_\_\_\_

4B. Employment: Does your complaint concern discrimination in employment by the department or agency? If so, please indicate below the base(s), actual or perceived, on which you believe these discriminatory actions were taken.

\_\_\_\_ Race/Color: \_\_\_\_\_  
\_\_\_\_ National origin: \_\_\_\_\_  
\_\_\_\_ Sex: \_\_\_\_\_  
\_\_\_\_ Religion: \_\_\_\_\_  
\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_ Disability: \_\_\_\_\_  
\_\_\_\_ Sexual Orientation \_\_\_\_\_  
\_\_\_\_ Gender Identity \_\_\_\_\_

5. To your best recollection, on what date(s) did the alleged discrimination take place?

Earliest date of discrimination: \_\_\_\_\_

Most recent date of discrimination: \_\_\_\_\_

Generally, complaints of discrimination must be filed within 180 days or 1 year of the alleged discrimination, depending on the terms of the statute.

6. Please explain as clearly as possible what happened, why you believe it happened, and how you were discriminated against. Indicate who was involved. Be sure to include how other persons were treated differently from you. (Please use additional sheets if necessary and attach a copy of written materials pertaining to your case.)

7. Please sign and date this Complaint Form below. Please note that if you are submitting this form by email a signature is not required because submission by email represents a signature.

(Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

Please feel free to add additional sheets to explain the present situation to us.

If you are sending this complaint by land mail please mail the Complaint Form to the following address:

NYS Division of Criminal Justice Services  
Office of Legal Services  
80 South Swan Street  
Albany, NY 12210

If you are emailing the Complaint Form the email address is the following:

[civilrights@dcjs.ny.gov](mailto:civilrights@dcjs.ny.gov)