CLIENT/APPLICANT COMPLAINT OF DISCRIMINATION

The Missouri Department of Social Services (DSS) provides services on a non-discriminatory basis. Difference in treatment in provision of services because of race, color, national origin/ancestry, sex (including pregnancy and gender identity), sexual orientation, age, disability, religion, veteran status or political beliefs (only with regard to Food Stamp Benefits) is prohibited. If you believe that you have been discriminated against in the provisions of services administered by DSS, you may file a complaint with the DSS Office for Civil Rights (OCR) by completing this form and returning it to:

Missouri Department of Social Services
Human Resource Center, Office for Civil Rights
P.O. Box 1527
Jefferson City, MO 65102-1527
Or by email at HRC.OCR@dss.mo.gov

Section One: Client/Applicant Information

Name	Cell/Personal Phone Number	Office Phone Number

Mailing Address (Street, City, State, Zip Code)	Social Security Number

Section Two: Complaint

Do you believe that the difference in treatment was based on your:

☐ Race ☐ Color ☐ National Origin/Ancestry ☐ Sex ☐ Sexual Orientation ☐ Age ☐ Disability
☐ Religion ☐ Veteran Status ☐ Political Beliefs (Only With Regard To Food Stamp Benefits)

Describe what occurred to make you believe that you were treated differently than other clients/applicants and the date the incident(s) occurred. Please be as specific as possible. (Use additional sheets as necessary.)

Explain why you believe that your membership in one or more of the protected categories listed above was the reason for the difference in treatment. (Use additional sheets as necessary.)

Provide the name of the DSS agency and/or person(s) who are responsible for the alleged difference in treatment.

Division / Unit / Person(s) Name

Address (Street, City, State, Zip Code)

Person(s) Involved

Did you report what happened to you to anyone at that agency?
☐ Yes ☐ No If yes, provide the name of the person(s) you talked with and what you reported to that person.

Do you know of anyone else who was treated in the same manner as you or anyone who witnessed what happened to you?
☐ Yes ☐ No If yes, provide the name of the person(s), their address and telephone number and a summary of what happened to them.

Client/Applicant Signature	Date

Section Three: DSS Employee Information
The employee should complete and forward to their immediate supervisor. The immediate supervisor is responsible for forwarding to OCR within five workdays.

Employee Name	Job Title	Office Phone Number

Division	Office/Facility Address	Work County

Date the client/applicant complaint was received	Date form provided to client/applicant

Supervisor Signature	Date

Provide a general description of discussion with client/applicant. (Attach written complaints.)