If Yes, please identify the individual(s) on whose behalf you are filing this complaint:

No

Yes

**Are you filing this complaint for someone else?**

FIRST NAME

LAST NAME

**Nebraska Department of Health and Human Services**

**ADA, SEC. 504, and ACA/SEC. 1557 COMPLAINT RESOLUTION FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YOUR FIRST NAME | |  | YOUR LAST NAME | |
| HOME PHONE (Please include area code) | |  | WORK PHONE (Please include area code) | |
| STREET ADDRESS | |  | | CITY |
| STATE | ZIP | E-MAIL ADDRESS (If available) | | |

**Who or what agency or department or office do you believe discriminated against you?**

|  |  |  |  |
| --- | --- | --- | --- |
| STREET ADDRESS |  |  | CITY |
| STATE | ZIP | PHONE (Please include area code) | |

**When do you believe that the discrimination occurred?**

LIST DATE(S)

**Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.** (Attach additional pages as needed)

**WITNESSES: Did anyone witness the incident(s) of discrimination? If so, please list names and phone numbers. (Attach additional pages as needed).**

DATE

*(*

*mm/dd/yyyy*

*)*

SIGNATURE

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

**The remaining information on this form is optional. Failure to complete this section will not affect the investigation into your Complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?**

(

Check all that apply

)

Other:

Foreign language interpreter (specify language):

Sign language interpreter (specify language):

Electronic mail

Large Print

Cassette tape

Computer diskette

TDD

Braille

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| FIRST NAME | |  | LAST NAME | |
| HOME PHONE (Please include area code) | |  | WORK PHONE (Please include area code) | |
| STREET ADDRESS | |  | | CITY |
| STATE | ZIP | E-MAIL ADDRESS (If available) | | |

**Have you filed your complaint anywhere else? If so, please provide the following.**(Attach additional pages as needed) PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

|  |  |
| --- | --- |
| DATE(S) FILED | CASE NUMBER(S) (If known) |

**To submit a complaint, please type or print, sign, and return completed Complaint Resolution Form to the ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator.**

**ADA, Sec. 504, and ACA/Sec. 1557 Compliance Coordinator**

**Nebraska Department of Health and Human Services**

**301 Centennial Mall South**

**Lincoln, NE 68509**

**Phone: (402) 471-4731**