



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)
DISCRIMINATION COMPLAINT

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.



If you have questions about this form, call OCR (toll-free) at:
1-800-368-1019 (any language) or 1-800-537-7697 (TDD)

YOUR FIRST NAME Brian		YOUR LAST NAME Smith	
HOME PHONE (749) 222-3333		WORK PHONE (749) 111-2222	
STREET ADDRESS 200 Parkway		CITY Somewhere	
STATE Michigan	ZIP 48304	E-MAIL ADDRESS (If available)	

Are you filing this complaint for someone else? ☒ Yes ☐ No

If Yes, against whom do you believe the discrimination was directed?

FIRST NAME Michelle	LAST NAME Yates
------------------------	--------------------

I believe that I have been (or someone else has been) discriminated against on the basis of: **please note you can mark both age & disability*

- ☐ Race / Color / National Origin ☐ Age ☐ Religion ☐ Gender (Male/Female)
☒ Disability ☐ Other (specify): _____

Who do you think discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION

Waiver Agency and Michigan Department of Community Health

STREET ADDRESS 6 th Floor Louis Cass Bldg., 320 S. Walnut		CITY Lansing
STATE Michigan	ZIP 48913	PHONE (517) 373-3500

When do you believe that the discrimination took place?

LIST DATE(S)

May 13, 2004 to Present

Describe briefly what happened. How and why do you believe you (or someone else) were discriminated against? Please be as specific as possible. (Attach additional pages as needed)

I am an attorney filing this complaint on behalf of Michelle Yates. Michelle applied for the home/community services pursuant to the federally funded Medicaid waiver program administered by Michigan Department of Community Health [state organization]. Michelle was denied the alternative services in violation of the ADA and its implementing regulations, and Section 504 of the Rehabilitation Act and its implementing regulations (28 C.F.R. 41.51; 45 C.F.R. 84.4), Townsend v. Quasim [328 F3d 511 (9th Cir. 2003)] and Olmstead v. Zimring (527 U.S. 581, 119 S.Ct. 2176).

Please sign and date this complaint.

SIGNATURE	DATE
-----------	------

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under 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. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from Health and Human Services (HHS) to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to our web site at: www.hhs.gov/ocr/discrimhowtofile.html. To mail a complaint see reverse page for OCR Regional addresses.

(The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.)

Do you need special accommodations for us to communicate with you about this complaint (check all that apply)?

- ☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD
- ☐ Sign language interpreter (specify language): _____
- ☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

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

FIRST NAME		LAST NAME	
HOME PHONE ()		WORK PHONE ()	
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

On or about July 22, 2004

CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

RACE (select one or more)

- ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
- ☐ Not Hispanic or Latino ☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English)

HOW DID YOU LEARN ABOUT THE OFFICE FOR CIVIL RIGHTS?

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged discrimination took place.

Region I - CT, ME, MA, NH, RI, VT Office for Civil Rights Department of Health & Human Services JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	Region V - IL, IN, MI, MN, OH, WI Office for Civil Rights Department of Health & Human Services 233 N. Michigan Ave - Suite 240 Chicago, IL 60601 (312) 886-2359; (312) 353-5693 (TDD) (312) 886-1807 FAX	Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions Office for Civil Rights Department of Health & Human Services 50 United Nations Plaza - Room 322 San Francisco, CA 94102 (415) 437-8310; (415) 437-8311 (TDD) (415) 437-8329 FAX
Region II - NJ, NY, PR, VI Office for Civil Rights Department of Health & Human Services 26 Federal Plaza - Suite 3313 New York, NY 10278 (212) 264-3313; (212) 264-2355 (TDD) (212) 264-3039 FAX	Region VI - AR, LA, NM, OK, TX Office for Civil Rights Department of Health & Human Services 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
Region III - DE, DC, MD, PA, VA, WV Office for Civil Rights Department of Health & Human Services 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499 (215) 861-4441; (215) 861-4440 (TDD) (215) 861-4431 FAX	Region VII - IA, KS, MO, NE Office for Civil Rights Department of Health & Human Services 601 East 12th Street - Room 248 Kansas City, MO 64106 (816) 426-7278; (816) 426-7065 (TDD) (816) 426-3686 FAX	Region X - AK, ID, OR, WA Office for Civil Rights Department of Health & Human Services 2201 Sixth Avenue - Mail Stop RX-11 Seattle, WA 98121 (206) 615-2290; (206) 615-2296 (TDD) (206) 615-2297 FAX
Region IV - AL, FL, GA, KY, MS, NC, SC, TN Office for Civil Rights Department of Health & Human Services 61 Forsyth Street, SW. - Suite 3B70 Atlanta, GA 30323 (404) 562-7886; (404) 331-2867 (TDD) (404) 562-7881 FAX	Region VIII - CO, MT, ND, SD, UT, WY Office for Civil Rights Department of Health & Human Services 1961 Stout Street - Room 1426 Denver, CO 80294 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave., S.W., Room 531H, Washington, D.C. 20201.