

COMPLAINT INTAKE FORM SALINA HUMAN RELATIONS COMMISSION

SALINA HUMAN RELATIONS DEPARTMENT
P.O. Box 736 - 300 West Ash - Salina, KS 67401
Office: 785-309-5745 - FAX: 785-309-5745

OFFICE ONLY
DATES
Initial: _____
Intake: _____

Please answer the following questions, telling us briefly why you feel you have been discriminated against. Answer all questions as completely as possible. If you have already filed with a STATE or FEDERAL AGENCY, or if your complaint is about something that happened over 1 year ago, STOP and call our office. Upon completing this form, mail it in and we will call to set up an appointment to talk with you concerning your complaint intake information.

*****Please be advised that housing complaints are dually filed with the U.S. Department of Housing and Urban Development.*****

EMPLOYMENT
 HOUSING
 PUBLIC ACCOMMODATIONS

COMPLAINANT INFORMATION (You): DOB: _____

NAME _____ TELEPHONE: HOME _____ WORK _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

I PREFER TO BE CONTACTED AT **WORK / HOME:** DAYS: _____ TIME: _____

PLEASE PROVIDE THE NAME OF A PERSON AT A DIFFERENT ADDRESS WHOM WE CAN CONTACT WHEN UNABLE TO REACH YOU:

NAME _____ RELATIONSHIP _____ TELEPHONE _____

RESPONDENT INFORMATION (Person who you believe is discriminating against you):

NAME _____ TELEPHONE _____

(LANDLORD OR PROPERTY MANAGER) OR (EMPLOYER/COMPANY)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLEASE FILL OUT THE APPROPRIATE BOX AS COMPLETELY AS POSSIBLE:

EMPLOYMENT

Job Location: _____

Job: Title: _____

Salary: _____

Date of Hire: _____

OR Hire Denial: _____

Date of Termination: _____

Supervisor: _____

HOUSING

Unit Location _____

Rent (wk/mo) \$ _____

Lease? Yes No

Length of Lease _____

Deposit \$ _____

Pet Deposit \$ _____

Date Moved in _____

OR

Date Refused _____

PUBLIC ACCOMMODATIONS

Business or Public Area where incident occurred: (be specific) _____

Date of Incident _____

Approximate time of Incident _____

"I believe I was discriminated against because of my..." (CHECK ALL APPLICABLE)

- RACE _____
(SPECIFY RACE)
- NATIONAL ORIGIN _____
(SPECIFY WHERE YOU WERE BORN, IF OUTSIDE USA)
- COLOR GENDER IDENTITY ANCESTRY _____
(SPECIFY YOUR ETHNIC GROUP - I.E. MEXICAN, INDIAN)
- SEX (GENDER) MALE FEMALE
- RELIGION _____
(SPECIFY YOUR DENOMINATION)
- AGE (EMPLOYMENT ONLY) DISABILITY: MENTAL PHYSICAL
- FAMILIAL STATUS (HOUSING ONLY)
- RETALIATION BY ASSOCIATION HARASSMENT OTHER: _____

Identify by name and job title, the individual(s) you believe discriminated against you (if known).

In what way were you discriminated against? Please note incident(s) you feel are discriminatory in nature. List according to date, earliest to latest, and include date: *(please attach any additional information)*

List names, addresses and telephone numbers of witnesses, and give description of the information they can provide that would support your allegations:

NAME _____ ADDRESS _____ TELEPHONE _____

NAME _____ ADDRESS _____ TELEPHONE _____

NAME _____ ADDRESS _____ TELEPHONE _____

NAME _____ ADDRESS _____ TELEPHONE _____

SETTLEMENT INFORMATION:

What do you feel would resolve the issue between you and the Respondent, and settle your complaint against them? Be as specific as you can. We will use this information to set up resolution between you and the Respondent:

This complaint is filed under the Salina City Code, Chapter 13, Equal Opportunity and Affirmative Action Ordinance.

Sec. 13-83. Submission of a false, misleading or incomplete complaint, statement, response or report states:

"Any person who knowingly and intentionally submits or files or causes to be submitted or filed, a false, misleading, or incomplete complaint, statement, response or report with the commission, the director or any of the department's personal, shall be guilty of a misdemeanor."

Signature of Complainant

Date of Signature