City and County of San Francisco Department of Human Services

TO: Department of Human Services
City and County of San Francisco
P.O. Box 7988
San Francisco, CA 94120

Name: _____

Attention: Civil Rights Office

Social Security Number: _____

I believe I have been discriminated against because of my:

☐ Limited English Skills ☐ Race ☐ National Origin ☐ Religion
☐ Age ☐ Disability ☐ Color ☐ Political Affiliation ☐ Marital Status
☐ Sex ☐ Sexual Orientation

Date of Incident: _____ Program Name: _____

Name and title of the person who discriminated against me:

_____

The nature of the action, decision or condition which caused me to file this complaint is as follows:

_____

_____

_____

_____

I wish the following action taken: _____

_____

_____

The above information is true and complete to the best of my knowledge:

_____
(Please sign your name) (Date)

Address: _____

_____

Phone: _____

Form 8019 (12/02) Complaint of Discriminatory Treatment