DEPARTMENT OF CHILD SUPPORT SERVICES LANGUAGE ACCESS COMPLAINT FORM

Use this form to record complaints related to language access with the California Department of Child Support Services. Please return this form and any related documentation to the Equal Employment Opportunity Office, Fax #: 916.464.0199; email: <u>personnelhelp@dcss.ca.gov</u>; or mail to: Department of Child Support Services, Equal Employment Opportunity Office, P.O. Box 419064, Rancho Cordova, CA 95741-9064.

1. CONTACT INFORMATION		
Name:		
Address:		
Phone Number:		
Email:		

2. COMPLAINT DETAILS			
Date of Incident:			
Department/Agency:			
Location or Address:			
Language Access Issue(s):	(Check all that apply) Lack of forms/materials in the language I needed Lack of bilingual personnel I was not offered an interpreter Other: (please specify below)		
What language did you need assistance with?	Spanish Mandarin Russian Cantonese		
Brief Description: Please b	e specific. Attach additional pages if necessary.		

3. FORM ASSISTANCE				
Did someone assist you in completing this form?		Yes (input information below)		
		No (leave blank below)		
Name:				
Organization:				
Phone Number:				
Email:				

DO NOT WRITE IN THIS BOX (DEPARTMENTAL USE ONLY).

Date Received:	
Action Taken:	
Contact Person:	
Phone:	
Email:	