Request for Fair Hearing Form

Age   Denial
Race   Exclusion
Sex   Failure to act with promptness
Origin   Dissatisfaction with service/treatment
Handicap
Religion

Name ____________________________________________________________________      _____________________________________      ____________________________________
                                                                                   First                       Middle                               Last             County of Residence                           Telephone Number
Address ____________________________________________________________________ Street Address                     City                                     State                           Zip

Program or Service involved:
___________________________________________________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________________________________________________

Please state the nature of your complaint in detail. If additional space is needed, please use a separate sheet of paper.
___________________________________________________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________________________________________________

Give the name(s) and address(es) below of staff you believe discriminated against you or treated you inappropriately. If more than one, list all.

Name ____________________________________________________________________ Name ____________________________________________________________________ Name ____________________________________________________________________
Title           Title                                                                                    Title
Address          Address                                                                              Address
City                             State                           County  City                                  State                                   County

The actual day or the most recent date when the alleged act occurred:
Time of Day ___________________ Month ___________________ Day ___________________ Year ___________________

Place of agency action involved _____________________________________________________________________________________________

Signature of Complainant ____________________________________________________________________  Signature of Authorized Representative, if appropriate ____________________________________________________________________

Within 30 days of the action you wish to appeal, forward your complaint to: Cheryl H. Allen, Executive Director
Community Action of Southern Kentucky, Inc.
921 Beauty Avenue, P. O. Box 90014
Bowling Green, Kentucky 42102-9014

CAK # 1-800-456-3452  CHR Ombudsman # 1-800-372-2973