OHR QUESTIONNAIRE-LONG-TERM CARE FACILITY

Required Fields

1. COMPLAINANT

*Today's Date: | *Name: | Preferred Name:

*Address: | *City/State/Zip:

E-mail: _____

*Home Tel #: _____

Work Tel #: _____

* What language do you prefer to communicate in?
☐ English ☐ Spanish ☐ Amharic ☐ Chinese ☐ Vietnamese ☐ Korean
☐ French ☐ Other (Please list) _____

IF REPRESENTED BY LEGAL COUNSEL, PLEASE PROVIDE THE FOLLOWING:
Name: _____ **Telephone/Fax:** _____
Address:_____ **E-mail Address**_____
*Please note: If you are represented by counsel or retain counsel prior to your scheduled Intake interview, the counsel must either (1) be present with you for the duration of your Intake interview, or (2) withdraw his/her appearance from the interview by submitting a letter to the Office indicating that the interview may take place without his/her representation.

Do you require a reasonable accommodation? If so, please explain:
_____

Do you require language interpretation? If so, what language? _____

2. RESPONDENT

Name of company or organization:

Name and Title of principal officer (i.e. President, Owner, Human Resources Manager):

Address **City/State/Zip**

*Facility Type:
☐ Nursing home
☐ Assisted living residence
☐ Community-residence facility

Tel #: **Fax #:** **E-mail Address:**

3. BASIS OF COMPLAINT

The basis is one of the below listed categories to which you belong and believe that you were treated differently because you belong or are perceived to belong in that category.

***Do you feel you were discriminated against because of your actual or perceived: (Please check appropriate box).**

☐ Sexual Orientation ☐ Gender Identity or Expression ☐ HIV status

4. JURISDICTION

***Please check all that apply:**

☐ Alleged violation occurred in the District of Columbia.

☐ Alleged violation occurred 365 days or less from today´s date.

☐ You have not commenced any other action, civil, criminal, or administrative in any other forum based on the same unlawful discriminatory practice described herein.

5. ISSUE OF COMPLAINT

***What action was taken that made you feel you were treated differently?**

☐ Denied admission
☐ Refusal to transfer or forcible transfer
☐ Discriminatory discharge or eviction
☐ Denied room-sharing request
☐ Discriminatory room assignment
☐ Discriminatory identification policy
☐ Pronoun misuse
☐ Denied right to privacy or free association
☐ Denied gender-consistent clothing, accessories, or cosmetics
☐ Denied medical or nonmedical care
☐ Non-essential staff present during physical exam
☐ Lack of visual barriers to provide privacy
☐ Denied right to refuse exam, observation, or treatment

5. ISSUE OF COMPLAINT (cont.)

*Date of alleged incident:_____

Person who discriminated against you (if known):

Name:_____ Title: _____

How is this person different from you? (i.e. what is this person's protected basis? See Section 3 for complete list of basis.)

_____

Have you tried to resolve this matter with the Respondent? If so, please describe with whom you spoke and their response:

_____

_____

_____

*6. YOUR COMPLAINT

Describe in detail the incident(s) that led you to file a complaint of discrimination. Please list dates as well as the name(s) of the person(s) who discriminated against you.

The submission of the OHR questionnaire constitutes the date of filing for statute of limitation purposes.
A complete and submitted OHR questionnaire satisfies the requirements of 4DCMR 705.4, 705.5

Please return this form by email to ohr.intake@dc.gov or 441 4th Street NW, Suite 570N, Washington DC, 20001.

The DC Office of Human Rights was established to eradicate discrimination, increase equal opportunity and protect human rights for persons who live, work, or visit the District of Columbia. The receipt of this complaint form by the Office of Human Rights will lead to an intake interview.

_____ _____

*Signature of Potential Charging Party (please type full name)

*Date