

TEXAS WORKFORCE SOLUTIONS COMPLAINT INFORMATION FORM

FOR TWC USE ONLY

Date Received
/ /

Part I.

Complainant's Information	Respondent's Information									
1. NAME OF COMPLAINANT (Last, First, Middle Initial)	4. NAME OF PERSON COMPLAINT MADE AGAINST									
2a. PERMANENT ADDRESS (Number, Street, City, State, Zip Code)	5. NAME OF EMPLOYER/ONE-STOP CAREER CTR (OSCC) OFFICE									
2b. TEMPORARY ADDRESS (if appropriate)	6. ADDRESS OF EMPLOYER/OSCC OFFICE									
3. PERMANENT TELEPHONE [] - [] OTHER/TEMPORARY PHONE [] - []	7. TELEPHONE NUMBER OF EMPLOYER/OSCC OFFICE [] - []									
8. DESCRIPTION OF COMPLAINT (If additional space is needed, use separate sheet(s) of paper and attach to this form.)										
9. To the best of your knowledge, which of the following program(s) was involved? <table style="width: 100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> Child Care Services Program <input type="checkbox"/> Employment/Job Service (ES) Program <input type="checkbox"/> SNAP: Employment & Training </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> Choices <input type="checkbox"/> Unemployment Insurance (UI) <input type="checkbox"/> Vocational Rehabilitation </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> Workforce Innovation and Opportunity Act (WIOA) <input type="checkbox"/> Other. Specify: _____ </td> </tr> </table>		<input type="checkbox"/> Child Care Services Program <input type="checkbox"/> Employment/Job Service (ES) Program <input type="checkbox"/> SNAP: Employment & Training	<input type="checkbox"/> Choices <input type="checkbox"/> Unemployment Insurance (UI) <input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Workforce Innovation and Opportunity Act (WIOA) <input type="checkbox"/> Other. Specify: _____						
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10. To your best recollection, on what date(s) did the alleged incident(s) take place? Date of first occurrence / / Date of most recent occurrence / /										
11. For this incident, have you filed a case or complaint with any of the following? <table style="width: 100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> US Department of Justice—Civil Rights Division <input type="checkbox"/> US Equal Employment Opportunity Commission (EEOC) </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> US DOL—Civil Rights Center <input type="checkbox"/> TWC—Civil Rights Division </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> Federal or State Court <input type="checkbox"/> Other _____ </td> </tr> </table>		<input type="checkbox"/> US Department of Justice—Civil Rights Division <input type="checkbox"/> US Equal Employment Opportunity Commission (EEOC)	<input type="checkbox"/> US DOL—Civil Rights Center <input type="checkbox"/> TWC—Civil Rights Division	<input type="checkbox"/> Federal or State Court <input type="checkbox"/> Other _____						
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12. Please list below any persons (witnesses, fellow employees, supervisors, or others) that we may contact for additional information to support or clarify your complaint. <table style="width: 100%; border: none; margin-top: 10px;"> <thead> <tr> <th style="width: 33%; text-align: center;">Name</th> <th style="width: 33%; text-align: center;">Address</th> <th style="width: 33%; text-align: center;">Phone Number</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Name	Address	Phone Number	_____	_____	_____	_____	_____	_____
Name	Address	Phone Number								
_____	_____	_____								
_____	_____	_____								
13. If alleging discrimination, which of the following best describes why you believe you were discriminated against? <table style="width: 100%; border: none; margin-top: 10px;"> <tr> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> Race. Specify: _____ <input type="checkbox"/> Color. <input type="checkbox"/> Religion. Specify: _____ <input type="checkbox"/> Sex. <input type="checkbox"/> Male <input type="checkbox"/> Female </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> National Origin. Specify: _____ <input type="checkbox"/> Age. Date of Birth: _____ <input type="checkbox"/> Disability. _____ <input type="checkbox"/> Citizenship. Specify: _____ </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> Political Affiliation. Specify: _____ <input type="checkbox"/> Reprisal/Retaliation (must be based on one of the listed discriminatory actions). Specify: _____ </td> </tr> </table>		<input type="checkbox"/> Race. Specify: _____ <input type="checkbox"/> Color. <input type="checkbox"/> Religion. Specify: _____ <input type="checkbox"/> Sex. <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> National Origin. Specify: _____ <input type="checkbox"/> Age. Date of Birth: _____ <input type="checkbox"/> Disability. _____ <input type="checkbox"/> Citizenship. Specify: _____	<input type="checkbox"/> Political Affiliation. Specify: _____ <input type="checkbox"/> Reprisal/Retaliation (must be based on one of the listed discriminatory actions). Specify: _____						
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14. CERTIFICATION: I certify that the information furnished is true and accurately stated to the best of my knowledge. I authorize the disclosure of this information to other enforcement agencies for the proper investigation of my complaint. I understand that my identity will be kept confidential to the maximum extent possible, consistent with applicable law and a fair determination of my complaint.										
15. PERSONS WISHING TO FILE COMPLAINTS OF DISCRIMINATION BY EMPLOYERS may file directly with the appropriate state or federal agency. (Ask the Complaint Representative for mailing address.)										
16. SIGNATURE OF COMPLAINANT	17. DATE SIGNED / /									

Part II. For Workforce Office Staff Use Only		
1. Migrant or Seasonal Farmworker? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, mail complaint directly to the Texas Monitor Advocate.	2. If non-Job Service/ES related, does complaint concern laws enforced by US DOL Wage and Hour Division [WHD] (formerly called Employment Standards Administration) or OSHA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Type of Complaints (Check Appropriate Boxes) <input type="checkbox"/> Job Service/ES Related Job Order Number _____ <input type="checkbox"/> Against Job Service <input type="checkbox"/> Against Employer <input type="checkbox"/> Alleged Violation of WIOA Regulations <input type="checkbox"/> Alleged Violation of Employment Law(s) <input type="checkbox"/> Non-Job Service/ES Related	4. Kind of Complaint (Check Appropriate Boxes) <input type="checkbox"/> Wage Related/Non-Payment of Wages <input type="checkbox"/> Housing <input type="checkbox"/> Child Labor <input type="checkbox"/> Pesticides <input type="checkbox"/> Working Conditions <input type="checkbox"/> Health/Safety <input type="checkbox"/> Migrant and Seasonal Agricultural Worker Protection Act (MSPA) <input type="checkbox"/> Disability Discrimination <input type="checkbox"/> Discrimination* <input type="checkbox"/> Other: Specify: _____	5. H-2A/Criteria Employer: <input type="checkbox"/> US /Domestic Worker <input type="checkbox"/> H-2A Worker <input type="checkbox"/> Wages <input type="checkbox"/> Transportation <input type="checkbox"/> Meals <input type="checkbox"/> Housing <input type="checkbox"/> Other _____
*FOR DISCRIMINATION COMPLAINTS ONLY: Individuals wishing to file complaints of discrimination may file either with the Texas Workforce Commission, State Equal Opportunity Officer, or with the US Department of Labor, Civil Rights Center, 200 Constitution Avenue, NW, Room N-4123, Washington, DC 20210.		
6a. Referrals to Other Agencies (Check One) → <input type="checkbox"/> Wage and Hour/US Dept. of Labor (DOL) <input type="checkbox"/> OSHA/DOL <input type="checkbox"/> TWC, Civil Rights Division <input type="checkbox"/> TWC, Labor Law Section (Wage Claims) <input type="checkbox"/> EEOC <input type="checkbox"/> Other _____ 6b. Follow-Up: 6c. Follow-Up Date: <input type="checkbox"/> Yes <input type="checkbox"/> Monthly ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Quarterly	7. Address of Referral Agency (Number, Street, City, State, ZIP Code and Telephone No.)	
8. Comments (If additional space is needed, use separate sheet of paper.) Provided ES Services? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain:		
9. Was Complaint Resolved? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain:		
10. Name and Title of Individual Receiving Complaint	11. Telephone Number [] -	
12. Workforce Solutions Office Address (Number, Street, City, Zip Code)	13. Workforce Solutions Cost Center (CC) Number: _____ LWDA Number: _____	

14. Signature	15. Date / /
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Instructions for Workforce Solutions Office Staff

PART I, Item 16. If complainant prefers to mail his or her complaint form, provide the appropriate state or federal agency mailing address.

PART II, Item 1. Mark “YES” when the individual filing the complaint meets all the following criteria: Worked an aggregate of 25 days or more during the preceding 12 months in agricultural-related work; 50 percent or more of the yearly income was derived from agricultural-related activities; and was not employed year-round by the same employer.

PART II, Item 3. Mark “Job Service/ES Related” and enter the job order number when the complainant was referred to the employer on a valid TWC job order. The “Against Job Service” will be marked when the allegation is against the employment service. “Against Employer” will be marked when the employer, named as the “Respondent” on the complaint, allegedly violated the “terms and conditions” of the job order, in other words, hours to be worked, wages to be paid, etc., or an employment-related law such as the Civil Rights Act of 1964, as amended, or the Fair Labor Standards Act.

PART II, Item 6. Check the agency to which the complaint was referred.

PART II, Item 7. Enter the contact information (name, address, telephone) of referred agency.