

Request for Fair Hearing Form

_____ Age
_____ Race
_____ Sex
_____ Origin
_____ Handicap
_____ Religion

_____ Denial
_____ Exclusion
_____ Failure to act with promptness
_____ Dissatisfaction with service/treatment

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	City	City
State	State	State
County	County	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