



WASHINGTON STATE HUMAN RIGHTS COMMISSION

PUBLIC ACCOMMODATION, CREDIT & INSURANCE INTAKE QUESTIONNAIRE

Telephone: (360) 753-6770 | FAX: (360) 586-2282 | Statewide Toll Free: (800) 233-3247 | Statewide TTY Toll Free: (800) 300-7525

PLEASE NOTE, BEFORE YOU PROCEED:

The Washington State Human Rights Commission has no jurisdiction over certain services or entities including but not limited to: police actions; the decisions of courts, city and county commissions, or other administrative or licensing agencies; Internet sites; the denial of public benefits; child support; court ordered visitation; prison and jails and their inmate programs; child or adult protective services actions; Native American tribes; and the federal government.

The Washington State Human Rights Commission has no jurisdiction over claims in which the last date of harm occurred more than 6 months prior to the filing date of this complaint or over issues that did not occur in Washington. Your complaint will not be accepted for investigation if it falls into one of the exceptions above, or does not meet jurisdictional requirements of RCW 49.60. If your complaint meets the jurisdictional requirements, please complete the entire form. If you require a reasonable accommodation to fill out this form, please contact us at 1-800-233-3247.

Mail To: Washington State Human Rights Commission Agency

711 South Capitol Way, Suite 402, P.O. Box 42490 Olympia, WA 98504-2490

Please Print

(Answer all questions as completely as possible. If you **do not know the answer** to a question, fill in blank with "not known". If a question **does not apply**, fill in blank with "n/a".) Limit attachments to only the information requested below. You will have an opportunity later to provide additional documents if necessary.

1). Personal Information:

Last Name: _____ First Name: _____ MI _____

Street /Mailing Address: _____ Apt. or Unit# _____

City _____ County _____ State _____ Zip _____

Phone:

Home (____) _____ Work (____) _____ Cell (____) _____

Email address: _____

Date of Birth: _____ Gender: Male ___ Female ___ Do you have a Disability? Yes ___ No ___

Please answer a) and b) below:

a) Are you ... ? (Check all that apply)

- Hispanic Caucasian American Indian Black Native Hawaiian
- Latino Asian Alaskan Native African-American Pacific Islander

b) What is your National Origin (country of origin or ancestry)? _____

If we are unable to contact you, please provide a name of a person **who does not live with you** so we may contact on your behalf.

Name: _____ Relationship: _____

Address: _____ City _____ State _____

Zip _____ County _____ Contact: Phone _____ Email _____



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2). I believe I was discriminated against by the following organization(s): (Check all that applies)

- Place of Public Accommodation Creditor Insurer

Organization Contact Information: (If you believe that more than one organization discriminated against you, please fill out an additional Intake Questionnaire).

Organization name: _____

Address: _____ City: _____ State: _____

County _____ Zip _____ Phone: (____) _____

Type of Business: _____

3). What is your relationship to the business (example: customer, patient, student, etc.)

4). What is the reason (Basis) for your claim of discrimination?

For example: If you feel that you were treated unfairly because of race, you should check the box next to "Race". If you feel you were **treated unfairly for several reasons**, such as your gender, religion, and/or national origin, you should check **all that apply**. If you complained about discrimination, participated in someone else's complaint, or filed a charge of discrimination, and a negative action was or taken, you should check the box next to "Retaliation".

- | | | |
|---|---|---|
| <input type="checkbox"/> Breast Feeding (Public Accommodation Only) | <input type="checkbox"/> Color (skin shade) | <input type="checkbox"/> Creed/Religion |
| <input type="checkbox"/> Marital Status (Credit & Insurance Only) | <input type="checkbox"/> National Origin | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Sex | <input type="checkbox"/> Race | <input type="checkbox"/> HIV/Hep C status |
| <input type="checkbox"/> Sexual Orientation/Gender Identity | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Retaliation |
| <input type="checkbox"/> Use of a trained dog guide or service animal by a person with a disability | | |
| <input type="checkbox"/> Veteran Status (Public Accommodation and Credit Only) | | |

If you checked **Color**, **Creed/Religion** or **National Origin**, please specify: _____

5). What happen to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and names(s) and title(s) of the person(s) who you believe discriminated against you. Please attach additional pages if needed, using the same format. (Example: 10/2/2015 – asked to leave restaurant by John Doe, waiter.)

a. Date: _____ Action: _____

b. Name and Title of Person(s) Responsible: _____



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6). Why do you believe these actions were discriminatory?

7). What reason(s) were you given for the acts you consider discriminatory?

By Whom? _____ His/Her job title: _____

8). Describe if there was anyone in the same or similar situation as you and how they were treated. For example, who else was dining at the same restaurant or shopping at the same store, etc. Provide the protected class, such as race, sex, age, national origin, religion, disability, etc. of these individuals, if known. For example, if your complaint alleges race discrimination, provide the race of each person; if your complaint alleges sexual discrimination, provide the sex of each person; and so on.

a). Of the persons in the same or similar situation as you, who was treated *better* than you?

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

b). Of the persons in the same or similar situation as you, who was treated *worse* than you?

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

c). Of the persons in the same or similar situation as you, who was treated the *same* as you?

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____



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— Answer questions 9-12 only if you are claiming discrimination based on disability. If not, skip to question 13. —

9). Please tell us if you are a person with a disability.

Check all that apply:

- Yes, I am a person with a disability.
- I am not a current person with a disability, but I was previously.
- No disability, but the organization believes I am a person with a disability.

10). What is the disability that you believe is the reason for the adverse action taken against you?

Does this disability prevent or limit your from doing anything? (For example: lifting, sleeping, breathing, walking, caring for yourself, working, etc.).

11). Do you have a service animal? What type of service animal and what service does it provide?

- Yes No

12). Are there any witnesses to the alleged discriminatory incident(s)? IF yes, please identify them below and tell us what information they have about the discrimination. (If necessary additional pages in the same format).

a. Full Name: _____ Relationship: _____

Contact: Phone _____ Email: _____

Address: _____ City _____ State _____

What information does this person have? _____

b. Full Name: _____ Relationship: _____

Contact: Phone _____ Email: _____

Address: _____ City _____ State _____

What information does this person have? _____

13). Have you already filed a complaint in this matter? Yes No

Provide name of agency and the date of filing: _____

Results? (if any) _____



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14). Have you sought help about this situation from anyone? Yes No
 (such as, an attorney, advocate, or other source)

Provide name of organization/person you have contacted for help and date of contact: _____

Results? (if any) _____

15). How did you hear about us?

This is the end of the *Public Accommodation, Credit & Insurance Intake Questionnaire*. Please review all pages.

If you need more information before filing a charge or you have concerns about the Washington State Human Rights Commission Agency notifying the entity about your charge, you may wish to check BOX 1.

To file a charge NOW, check BOX 2.

Check only one box!

BOX 1

<input type="checkbox"/>	<p>I want to talk with a Washington State Human Rights Commission Agent before deciding whether to file a charge. I understand that by checking this box I have <i>not</i> filed a charge with WSHRC. I also understand that I could lose my rights if I do not file a charge within 6 months of my knowledge of the discriminatory action.</p>
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BOX 2

<input type="checkbox"/>	<p>I want to file a charge of discrimination. I authorize the WSHRC to look into the discrimination I described in this Intake Questionnaire. I understand the entity that I accuse of discrimination will receive information about the charge, including my name. I also understand that the WSHRC can only accept charges of discrimination based on race, color, creed/religion, sex, national origin, disability, age, sexual orientation /gender identity, breast feeding, veteran status, marital status, HIV/Hep C status and retaliation for opposing discrimination.</p> <p>I understand that the Washington State Human Rights Commission has no jurisdiction over certain services or entities, Police issues, Native American tribes, the federal government or the internet. The WSHRC has no jurisdiction over claims in which the harm occurred outside Washington or when the last date of harm occurred more than 6 months prior to the filing date of this complaint. I understand that if my claim does not meet jurisdictional requirements, it will not be accepted for investigation and that there will be no follow-up on this inquiry from the Washington State Human Rights Commission Agency (WSHRC).</p>
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I declare under penalty of perjury under the laws of the State of Washington that I have read the foregoing and that it is true and correct.

Complainant's Signature _____

Today's Date _____