CIVIL RIGHTS COMPLAINT FORM FOR ALLEGATIONS OF PROGRAM DISCRIMINATION BY THE SOCIAL SECURITY ADMINISTRATION

INSTRUCTIONS

PURPOSE OF THIS FORM: The purpose of this form, SSA-437-BK, is to help you file a complaint of discrimination about a program or activity conducted by the Social Security Administration (SSA).

SSA POLICY: SSA policy requires us to conduct our programs and activities in a way that does not discriminate on the basis of: race, color, national origin (including limited ability to communicate in English), religion, sex (including sexual orientation and gender identity), disability, age, or parental status. No SSA officer, employee or agent may intimidate, threaten, harass, coerce, discriminate or otherwise retaliate against anyone who has filed a complaint of alleged discrimination or who has participated in any manner in an investigation or other proceeding raising allegations of discrimination.

FILING A COMPLAINT OF DISCRIMINATION: If you think that an SSA employee or Administrative Law Judge (ALJ) acted upon your claim based on bias or discrimination instead of the facts of your case, you may file a complaint of discrimination by using this form. Instead of using this form, you may write a letter stating the same information required by this form. If your letter is missing information, we will send you a copy of this form. We investigate complaints of discrimination that are complete, timely and within our jurisdiction.

Do not file a complaint of discrimination if you experienced a **customer service problem** not related to discrimination. Instead, contact SSA at: https://faq.ssa.gov/ics/support/ticketnewwizard.asp?style=classic&type=feedback.

COMPLAINTS ABOUT DECISIONS ON CLAIMS FOR PROGRAM BENEFITS: Do not file a complaint of discrimination if your complaint concerns a benefits decision you disagree with. If you want to ask SSA to change its decision about your benefits claim under a program SSA administers (such as DIB (Disability Insurance Benefits), SSI (Supplemental Security Income), child's benefits, widow's benefits, or retirement), **you must follow the procedures and deadlines for appealing the decision as described in the notice of appeal rights included with the decision.** If you believe SSA's benefits decision was based on discrimination, you must state this in your appeal and provide the facts on which you base your allegation.

IMPORTANT: If you disagree with an action SSA took on a claim for benefits, our program rules require you to appeal the action within a specific time period. **Filing a complaint of discrimination using this form** (or a letter stating the same information required by this form) **to complain that an SSA employee or Administrative Law Judge (ALJ) acted upon your claim for benefits based on bias or discrimination instead of the facts of your case will not extend the deadline for filing an appeal.**

COMPLAINTS ABOUT EMPLOYMENT WITH SSA: Do not use this form if your complaint concerns employment with SSA. Instead, you must contact an SSA Equal Employment Opportunity (EEO) Counselor within 45 days of the action you believe was based on discrimination. Contact an EEO Counselor at (866) 744-0374 or through SSA's Office of Civil Rights and Equal Opportunity intranet website.

FILING DEADLINE: You must file a complaint of discrimination within **180 days** of the action you allege was based on discrimination. If the action took place more than 180 days ago, you must explain why you waited to file the complaint. SSA will waive the 180-day deadline if we believe you had good cause for filing late. We must dismiss complaints filed late without good cause.

FILING A COMPLAINT BY MAIL OR EMAIL: To file a complaint of discrimination, you or someone helping or representing you, should complete a signed and dated copy of this form (or a letter stating the same information required by this form). If your complaint of discrimination is incomplete or unsigned, we will send it back to you for correction which will delay our consideration of your complaint. Save a copy of your completed complaint of discrimination. Mail the original to:

Social Security Administration
OCREO - CCM
Attn: Civil Rights Complaints
6401 Security Boulevard
WHR-3350
Baltimore, Maryland 21235

You may choose to email your complaint of discrimination as an attachment to civil.rights.program.complaint.intake@ssa.gov. Please note that this email mailbox is not a secure means of communication with us. It is possible that information you include in an email, including any attachments, can be intercepted by others outside of SSA and used by those third parties for purposes you did not intend. For this reason, please limit personal information about both yourself and others when transmitting complaints to us via email. Please include only the minimal information that is necessary to convey your complaint. Do not include any Social Security numbers with the complaint.

QUESTIONS. For questions about or assistance with the civil rights discrimination complaint process, you or someone helping or representing you may reach us by mail or email as described above or by telephone, toll-free, at (866) 574-0374.

Program Discrimination Complaint Form

1. Person(s) allegedly discriminated against (For additional persons, please provide the information on a separate sheet):

Name			
Address			
City		State	ZIP
Daytime phone number			

2. Person completing this form, if different from the person identified in Question 1. State your name, address and contact information.

Name			
Address			
City		State	ZIP
Daytime phone number			

3. Please explain your relationship to any person(s) identified in Question 1:

4. It is against SSA policy for a program conducted by SSA to discriminate against you based on your race, color, national origin (including limited ability to communicate in English), religion, sex (including sexual orientation and gender identity), disability, age, or parental status. (Note: Not all of these bases apply to all of SSA's programs.) It also is against SSA policy to retaliate against you because you filed a discrimination complaint or to retaliate against anyone who assisted you in filing a complaint. Please tell us why you believe you were discriminated against.

5. On what date(s) did the alleged discrimination take place?

6. Complaints must generally be filed within 180 days of the alleged discrimination. If the date of discrimination listed above is more than 180 days ago, you may request a waiver of the time limit for filing a complaint. If you wish to request a waiver, please explain why you waited until now to file your complaint.

7. Please describe the action SSA took that you believe was based on discrimination or the SSA policy, procedure, or practice that you believe is discriminatory. Explain why you believe you were discriminated against. Identify any people you allege were treated differently than you because of discrimination. Give the name(s) of anyone involved and describe what they did. If the action happened in an SSA office, give the office's address (street, city, State). If the action happened during a phone call with SSA, give the number you called or were called from, whom you talked to, and the date and time of the call. You may use additional sheets if necessary. You may also attach copies of any documents that will help us understand what happened.

8. If you believe that you were retaliated against for filing or participating in a prior discrimination complaint, please explain the circumstances below. Be sure to explain how you were retaliated against and describe what actions you took that you believe led to the retaliation.

9. Please list the names, addresses, and phone numbers of any persons who may have witnessed, or have additional information about, the action(s) that are the subject of your complaint. If the person is an SSA employee, it is sufficient to give the employee's name and the name or location of the SSA office.

Name	Address	Phone Number

10. Did you write to or talk with any SSA official(s) about the actions you believe to be discrimination? If so, give the name of the person(s) you talked to, the address of the person's office (street, city, State) or the phone number you called, the date(s) you talked, and describe what happened.

11. What would you like SSA to do as a result of your complaint? What remedy or accommodation are you seeking because of the discrimination you allege?

12. Have you, or has the person allegedly discriminated against, filed a complaint about this matter with any other agency or organization? ☐ Yes ☐ No

12A. If yes, identify the name and location of the office(s) where the complaint was filed.

12B. When was the complaint filed? _____
MM/DD/YYYY

13. How did you learn that you could file this complaint?

14. **We cannot accept a complaint if it has not been signed. Please sign and date this complaint form below.**

Signature of person allegedly discriminated against:	Date

If someone is helping or representing the person allegedly discriminated against (identified in Question 1) to file this complaint of discrimination, both of you must sign and date this form. If the person allegedly discriminated against is not able to sign and date this complaint form, please explain why, and be sure to complete Question 1 so we can contact that person.

Signature of person completing this form:	Date

The remaining information on this form is optional.
Failure to answer these voluntary questions will not affect SSA's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ CD with Word file ☐ Audio CD ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____

☐ Other (specify): _____

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (select all that apply)

☐ Native American or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

Preferred Language (if other than English): _____

Privacy Act Statement
Collection and Use of Personal Information

Section 702(a) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide the information may prevent us from processing your complaint.

We will use the information you provide to process your complaint. We may also share your information for the following purposes, called routine uses:

- To a Federal, State, or local agency for law enforcement purposes concerning a violation of law pertaining to the records in this system; and

- To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal employees, when they are performing work for the Social Security Administration (SSA), as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0275, entitled Civil Rights Complaints Filed by Members of the Public, as published in the Federal Register (FR) on January 11, 2006, at 71 FR 1874. Additional information, and a full listing of all our SORNS, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about **60** minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*****:** *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*