

Chautauqua Works

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WIOA Title I Complaint/Grievance Procedure

Local Workforce Development Area Name: Chautauqua

Designated Grievance Officer: Clara Swanson
Phone: (716) 487-5110
Email: cswanson@chautauquaworks.com

Designated Hearing Officer: Kathleen Geise
Phone: (716) 487-5116
Email: kgeise@chautauquaworks.com

1. The process starts when a complaint/grievance is filed with the Grievance Officer. The officer must log the complaint, and review it to seek a resolution.
 - a. Note, while not required, customers are encouraged to file complaints using the Customer Complaint Information Form (Attachment C). This same form can be utilized to file complaints under the Title III Wagner-Peyser program and/or for discrimination complaints filed under Section 188 of the Workforce Innovation and Opportunity. Appropriate procedure should be followed when filing a complaint in those cases.
2. A hearing will be scheduled at least thirty (30) calendar days, but no more than forty-five (45) calendar days, from the filing of the complaint/grievance to provide the person or entity (Complainant) with an opportunity to present witnesses and other evidence.
 - a. Notice of the grievance hearing shall be in writing and include: the date, the time, and place of hearing; a statement of the law and regulations under which the hearing is to be held, and a short and clear statement of the complaint/grievance.
 - b. Note that if the Grievance Officer is successful in reaching an informal resolution with the Complainant prior to the date of the scheduled hearing, the scheduled hearing will be adjourned.
3. At the Local Area level, a written Decision must be issued to the Complainant by the Hearing Officer within sixty (60) calendar days of the filing of the complaint/grievance.
4. Complainants not in receipt of a written decision within sixty (60) calendar days of filing the complaint/grievance have the right to request a State Level review. Such a request must be filed within fifteen (15) calendar days from the date on which the Complainant should have received a written decision. The request for State Level Review must be filed with the State Level Grievance Officer. State level appeals must be submitted by certified mail, return receipt requested to:

State Level Grievance Officer
New York State Department of Labor
W. Averell Harriman State Office Building Campus
Building 12, Room 440
Albany, New York 12240-0001

5. The Complainant also has the right to request a State Level review of an adverse decision issued by the Local Level Hearing Officer. Such request must be filed with the State Level Grievance Officer within ten (10) calendar days of receipt of the adverse decision.

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Customer Complaint Information Form

Complaint number: _____

Instructions: If you have a complaint, please complete this form and submit it to Career Center staff. If this is a discrimination complaint, you must either submit this form to the Career Center Equal Opportunity officer, or send it to: **New York State Department of Labor, Division of Equal Opportunity Development, State Office Campus, Building 12, Room 540, Albany, NY 12240.** If needed, attach extra pages and any documents about your claim.

1. Complainant (fill in your information)

First name _____ MI _____ Last name _____

Address _____ City _____ State _____ Zip _____

Alternative address (if applicable) _____

SSN (Optional) _____ Home telephone (_____) _____ Alternate telephone (_____) _____

E-mail address _____

What are the most convenient time and method for us to contact you about this complaint? _____

I give my consent to share information regarding this complaint to (list name(s) of family members, friends etc. that can receive information regarding your complaint): _____

2. Respondent (fill in the information for the subject of your complaint)

Agency, business or employee you are making complaint against: _____

Address _____ City _____ State _____ Zip _____

Telephone (_____) _____

2a. Is the respondent a Career Center? Yes No

If yes, is this complaint regarding Training Customer Service Other _____

2b. Is the respondent a business? Yes No

If yes, were you referred to this business by Career Center staff? Yes No If yes, when? _____

2c. Is the respondent a Farm? Yes No

2d. What is your complaint about (check all that apply)?

Wages/unpaid wages Child Labor Health and Safety Working Conditions Housing Transportation

Meals Pesticides Other _____

2e. Is your complaint about discrimination? Yes No

3. Briefly describe your complaint. Be as clear as possible. If you believe you were discriminated against, please describe in detail how this happened.

a. What happened? _____

b. Who was involved? (Witnesses, fellow employees, supervisors, etc.) Provide name, address and telephone number, if known.

c. When and where did it happen (include date)? _____

d. If you believe you were treated differently, describe how. _____

4. Were you offered employment services? Yes No

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5. How would you like this complaint to be resolved? _____

If this is a discrimination complaint, fill out numbers 6-10. If this is not a discrimination complaint, go to number 11.

6. Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Race (specify) _____ | <input type="checkbox"/> Color (specify) _____ |
| <input type="checkbox"/> Religion (specify) _____ | <input type="checkbox"/> National Origin (specify) _____ |
| Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Arrest & conviction record (specify) _____ |
| <input type="checkbox"/> Disability (specify) _____ | <input type="checkbox"/> Marital status (specify) _____ |
| <input type="checkbox"/> Citizenship (specify) _____ | <input type="checkbox"/> Genetic predisposition & carrier status (specify) _____ |
| <input type="checkbox"/> Sexual harassment _____ | <input type="checkbox"/> Veteran status (specify) _____ |
| <input type="checkbox"/> Age (specify date of birth) ____/____/____ | <input type="checkbox"/> Sexual orientation _____ |
| <input type="checkbox"/> Political affiliation (specify) _____ | <input type="checkbox"/> Victim of Domestic Violence _____ |
| <input type="checkbox"/> Reprisal/retaliation (specify) _____ | <input type="checkbox"/> Other (specify) _____ |

7. Why do you believe these events happened? _____

8. Do you have an attorney or other representative for this complaint? Yes No If "Yes," please fill out the following:

Name _____ Telephone (____) _____
 Address _____ City _____ State _____ Zip _____

9. Have you filed a case or complaint about this incident with any of the following?

- | | |
|---|--|
| <input type="checkbox"/> US Dept. of Justice, Civil Rights Division | <input type="checkbox"/> NYS Dept. of Labor, Division of Equal Opportunity Development |
| <input type="checkbox"/> US Equal Employment Opportunity Commission | <input type="checkbox"/> NYS Division of Human Rights |
| <input type="checkbox"/> US Dept. of Labor, Civil Rights Center | <input type="checkbox"/> Federal or State Court |
| <input type="checkbox"/> Other _____ | |

10. For each agency checked in number 9, please fill out the following information:

Agency _____ Date Filed ____/____/____	Agency _____ Date Filed ____/____/____
Case or docket no. _____	Case or docket no. _____
Date of trial or hearing _____	Date of trial or hearing _____
Location of agency or court _____	Location of agency or court _____
Name of investigator _____	Name of investigator _____
Status of case _____	Status of case _____
Comments _____	Comments _____

11. I certify that the information furnished above is true and accurately stated to the best of my knowledge. I authorize the disclosure of this information to 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.

_____ Complainant Signature _____ Date

Staff receiving complaint _____ (Print Name) _____ Signature _____ Date

Career Center _____ Telephone (____) _____