State of Illinois
Governor's Office of Management and Budget
www.budget.illinois.gov

401 S. Spring Street
Room 603 Stratton Building
Springfield, IL 62706
main line: 217.782.4521

GOMB Language Access Complaint Form

Federal and State laws require the State of Illinois to comply with all nondiscrimination laws, including but not limited to the federal Civil Rights Act of 1964, the Americans with Disabilities Act, and the Illinois Human Rights Act. Illinois must ensure all individuals have meaningful access to services, benefits, and programs provided by the State. If you believe that you have been denied or restricted access to the Governor's Office of Management and Budget services, benefits, or programs based on your inability or perceived inability to speak or understand English or you have a limited English proficiency, please complete this form, and submit it to the Language Access Coordinator for the Governor's Office of Management and Budget.

1. Information About You

Your Name and Address:

_____
Name

_____
Address

_____
City State ZIP

Your Telephone Number(s):

Primary phone number: (____)_____

Alternate: (_____)_____

What is the best time for us to contact you?

_____

2. Information About Your Complaint

Please tell us where the incident(s) occurred:

_____
_____
_____
_____
_____

Please identify, as best you can, the State of Illinois employee(s) and, if applicable, other person(s) who may have been involved in the incident(s):

_____
_____
_____
_____
_____

Please tell us the approximate time(s) and date(s) when the incident(s) occurred:

_____
_____
_____
_____
_____

3. Description: Please describe in your own words what happened. Also, please explain why you believe discrimination occurred. Be sure to include such information as:

- Who was involved and what they did or said, including any offensive or derogatory language used,
- How you, or another, were treated differently from others,
- How you tried and were unable to access GOMB information, services, etc.
- If you were provided forms to sign that were in a language other than your primary language.

Please attach any written or other material you have pertaining to your complaint.

4. Please provide us with any other information you think is important to your complaint.

5. Witnesses: Please list any persons you wish us to contact for additional information about your complaint.

Name	Address	Telephone

6. Basis of Complaint:

Which Language Access type was denied, or what services have you not received in your preferred Language.

- ☐ In person Interpreter
- ☐ Telephone Interpreter
- ☐ Forms
- ☐ Written Notices
- ☐ Service Plan (Language)
- ☐ Notification of Appeal Rights (Language)
- ☐ Local Office did not offer Language assistance
- ☐ Sign Language and Deaf/Hard of Hearing assistance
- ☐ Lack of signage informing you of your rights to Language Services

7. Language Access:

1. What do you consider 'your' language (What language do you **speak** at home?)_____
2. Do you **read** and **write** in your language? Yes ☐ No ☐
3. Do you fluently speak, write, or read other languages? Yes ☐ No ☐
   If so, which languages? _____
4. Did you have help completing this form? Yes ☐ No ☐
   If so, please list the name and contact information for the person(s) who assisted you:_____

_____

_____

Complainant Signature Date

Interpreter Name/ID number (if used):

Send to:

Jennifer Cavanaugh
Language Access Coordinator
Governor's Office of Management and Budget
Room 603 Stratton Building
401 South Spring Street
Springfield, Illinois 62706
Or email to: GOMB@illinois.gov