

***DELAWARE WIOA Title I Discrimination Complaint Log** (July 1, 2020-June 30, 2021)

Name of WIOA Service Provider:

Month/Date/Year of Submittal:

| Date of Complaint (A) | Name of Complainant (B) | Address of Complainant (C) | Status of Complainant (D) | DOL-funded Program (E) | Date of the Alleged Discriminatory | Grounds/ (Bases) of Complaint (G) | Description/Issue of Complaint (H) | Name of Respondent (I) | Is Respondent a recipient? Yes or No (J) | Date Completed (K) | Results/Action (L) | Referred to: (M) | ADR Yes or No (N) | Date Appeal Sent (O) | Person Performing Review (P) |
|-----------------------|-------------------------|----------------------------|---------------------------|------------------------|------------------------------------|-----------------------------------|------------------------------------|------------------------|--|--------------------|--------------------|------------------|-------------------|----------------------|------------------------------|
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

Submitted by: Date:

Program Type (check one) OSY OST/TTA SYEP Other (Specify) _____

Dislocated Worker Yes No

Adult Yes No