



Taking Action

How to File A Charge When You've Been Treated Unfairly by an Employer Because You Have a Disability



Self-Help Guide

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Do you know what to do if you have been treated unfairly or discriminated against by an employer because of your disability?

This guide will tell you:

- 1. WHERE TO GO if you want to file a charge of discrimination against an employer that has treated you unfairly because of your disability.**
- 2. HOW MUCH TIME you have to file the charge.**
- 3. WHAT INFORMATION you will need to file the charge.**
- 4. WHAT WILL HAPPEN when you file the charge.**

1. WHERE can you go to file a charge against an employer?

If you believe that you have been treated unfairly or have been discriminated against because of your **physical or mental disability** you can file a charge with either the:

**United States Equal Employment -OR-
Opportunity Commission (EEOC)**
3300 North Central Avenue
Suite 690
Phoenix, AZ 85012
(602) 640-5000 (Voice)
(602) 640-5072 (TTY)
(800) 669-4000 (voice for people
living outside Phoenix)
(800) 877-8339 (TTY for people
living outside Phoenix)

Arizona Attorney General's Office (ACRD)
Civil Rights Division
400 West Congress
Suite 215
Tucson, Arizona 85701
(520) 628-6500 (voice)
(520) 628-6872 (TTY)

Arizona Attorney General's Office
Civil Rights Division
1275 West Washington
Phoenix, AZ 85007
(602) 542-5263 (voice or TTY)

Disability discrimination is unlawful under both federal and Arizona law. The EEOC enforces the Americans with Disabilities Act (the "ADA"), which is the federal law. The ACRD enforces the Arizona law (the Arizonans with Disabilities Act) against disability discrimination. You can file your charge of discrimination with either the EEOC or the ACRD, as long as you file by the proper deadlines (see below for more information on deadlines). If you meet the deadlines, the agency you choose to file with will automatically file your charge with the other agency. That way, you can file one charge that will start legal action under both federal and state law.

There is no cost to file a charge of discrimination and you do not need to have a lawyer to file your charge.

2. HOW MUCH TIME do you have to file a charge against an employer?

You have up to 300 days from the date of the employer's discriminatory act to file your charge of disability discrimination under the ADA. However, you only have 180 days from the date of the employer's discriminatory act to file a charge under the Arizonans with Disabilities Act. This means that

if you file your charge with either the EEOC or the ACRD by the 180 day deadline, it will be filed under both laws. If you miss the 180 day deadline, you can still file a charge under the ADA before 300 days have passed.

Important: If you do not file a charge of discrimination, you will not be able to file a lawsuit later under the ADA or the Arizonans with Disabilities Act.

3. WHAT INFORMATION will you need to file a charge against an employer?

You will need to know some things in order to fill out the charge form, whether you fill it out yourself or fill it out with the help of the EEOC or ACRD. You will also need to fill out two questionnaires. Samples of these questionnaires are attached as Appendices A and B to this guide. The charge form should explain why you feel that you were treated unfairly by your employer because of your disability. In order to fill out the charge form, you will need to provide the following information:

- ✓ Your name, address and telephone number. You will also be known as the “charging party.”
- ✓ The employer's name, address, telephone number, and number of employees. The employer will also be known as the “respondent.”
- ✓ Whether you were treated unfairly or discriminated against because of your disability, race, color, religion, sex or national origin.
- ✓ A list of the unfair or discriminatory acts that the employer carried out against you.

Examples:

- Your boss paid you less than your co-workers because you have a disability
- Your boss fired you because of your disability
- Your boss told you “no” when you asked for certain changes to your workplace so you could do your job
- ✓ The nature of your disability or the nature of the other person's disability if you have been treated unfairly for helping a person with a disability.
- ✓ The reasons you think you were treated unfairly.
- ✓ The details of what happened.
- ✓ Any papers or documents you have that talk about the unfair treatment or discrimination.
- ✓ The names, addresses and home and work telephone numbers of other people who may have seen or may know about the unfair treatment or discrimination. These people are called “witnesses.”

- ✓ Copies of any important papers you have with information related to the unfair treatment or discrimination.

Remember: If you file a charge, the charge form will be assigned a number. This number is usually kept in the upper right hand corner of the form. You must know that number when you call to talk to someone about your charge or provide information to the EEOC or the ACRD about your charge.

Important Note Regarding Mediation:

When you meet with the EEOC or the ACRD to file a charge, you can ask for a mediation to work out the problem with the employer. A mediation is a meeting with you, the employer and a person who is trained to help people resolve problems. A mediation is free and it often takes less time. You can bring a friend, a lawyer or an advocate to help you during the meeting.

The Arizona Center for Disability Law has a free DVD on the mediation process. You can view this DVD on our website at www.azdisabilitylaw.org. Or, you can contact the Center and a copy will be sent to you.

4. WHAT WILL HAPPEN when you file a charge?

The EEOC or the ACRD will take a number of steps once you file a charge. Here is a list of the things that will usually take place once you file a charge:

- 1) One person will be assigned to take a closer look at your case. This person is called an investigator. The investigator is the person whom you will contact if you have questions about your case.
- 2) Within 10 days of receiving your charge form, the EEOC or the ACRD office will send a copy of your charge to the employer. The employer must usually send a response to the charge within 30 days from the date they receive the charge.
- 3) The EEOC or the ACRD will then review the information both you and the employer have provided. The EEOC or the ACRD may give both of you a chance to provide more information to prove that your side of the story is correct.
 - The EEOC or the ACRD may ask for specific information from you or from the employer.
 - The EEOC or the ACRD may also interview witnesses who know something about the acts explained in your charge.
 - You and the employer may be asked to provide more evidence or attend a meeting to talk about the charge or come to some agreement about what needs to be done to work out the problem.

Note: The EEOC and the ACRD have the right to decide how far they want to pursue the matter.

- 4) After reviewing the charge, the EEOC or the ACRD will let you know whether they have

decided to dismiss your charge or continue their investigation.

- 5) If the EEOC or the ACRD decides to dismiss your charge and not pursue it further, they will provide you with a “right to sue” letter. If you wish, you may then file a private lawsuit. **This lawsuit must be filed within 90 days of receiving the “right to sue” letter, or you will lose your right to file a lawsuit.**

- 6) If the EEOC or the ACRD decides to investigate your charge and they determine that the employer did discriminate against you, they will try to get the employer to give you the relief that you deserve, such as back wages or disability awareness training. If the employer refuses, the EEOC or the ACRD will then give you a “right to sue” letter. If you wish, you may then file a private lawsuit. **This lawsuit must be filed within 90 days of receiving the right to sue letter, or you will lose your right to file a lawsuit.**

Note: In rare cases the EEOC or the ACRD may file a lawsuit against the employer.

If you have questions about this guide or other questions your legal rights as a person with a disability, please write or call the Arizona Center for Disability Law at:

5025 E. Washington
Suite 202
Phoenix, AZ 85034-2005
602-274-6287 (voice or TTY)
800-927-2260 (toll free)
602-274-6779 (fax)

Email: center@azdisabilitylaw.org

To get a list of our trainings or look at other Center self-advocacy guides, visit our web site at www.azdisabilitylaw.org

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Federal and state law can change at any time. If there is any question about the continued validity of any information in the handbook, contact the Arizona Center for Disability Law or an attorney in your community.

The purpose of this guide is to provide general information to individuals regarding their rights and protections under the law. It is not intended as a substitute for legal advice. You may wish to contact the Arizona Center for Disability Law or consult with a lawyer in your community if you require further information.

This guide is available in alternative formats upon request.

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EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
INTAKE QUESTIONNAIRE

Please immediately complete the entire form and return it to the U.S. Equal Employment Opportunity Commission (“EEOC”). **REMEMBER**, a charge of employment discrimination must be filed within the time limits imposed by law, generally within 180 days or in some places 300 days of the alleged discrimination. Upon receipt, this form will be reviewed to determine EEOC coverage. **Answer all questions as completely as possible, and attach additional pages if needed to complete your response(s). If you do not know the answer to a question, answer by stating “not known.” If a question is not applicable, write “n/a.”**

(PLEASE PRINT)

1. Personal Information

Last Name: _____, First Name: _____ MI: _____

Street or Mailing Address: _____ Apt Or Unit #: _____

City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Cell: (____) _____ Email Address: _____

Date of Birth: _____ Sex: Male ___ Female ___ Race: _____

National Origin / Ethnicity _____ Do You Have a Disability? Yes No

Provide The Name Of A Person We Can Contact If We Are Unable To Reach You:

Name: _____ Relationship: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Home Phone: (____) _____ Other Phone: (____) _____

I believe that I was discriminated against by the following organization(s): (Check those that apply)

Employer ___ Union ___ Employment Agency ___ Other (Please Specify) _____

2. Organization Contact Information

Organization #1 Name: _____

Address: _____ **County:** _____

City: _____ **State:** ___ **Zip:** _____ **Phone :(____)** _____

Type of Business: _____ **Job Location if different from Org. Address:** _____

Human Resources Director or Owner Name: _____ **Phone:** _____

Number of Employees in the Organization at All Locations: Please Check (√) One

Less Than 15 15 – 100 101 – 200 201 – 500 More 500

Organization #2 Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Phone : (____) _____

Type of Business: _____ Job Location if not at Org. Address: _____

Human Resources Director or Owner Name: _____ Phone: _____

Number Of Employees In The Organization At All Locations: please check (✓) one

Less Than 15 15 – 100 101 – 200 201 – 500 More 500

3. Your Employment Data (Complete as many items as you can)

Date Hired: _____ Job Title At Hire: _____

Pay Rate When Hired: _____ Last or Current Pay Rate: _____

Job Title at Time of Alleged Discrimination: _____

Name and Title of Immediate Supervisor: _____

If Applicant, Date You Applied for Job _____ Job Title Applied For _____

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

*FOR EXAMPLE, if you are over the age of 40 and feel you were treated worse than younger employees **or** you have other evidence of discrimination, you should check (✓) **AGE**. If you feel that you were treated worse than those not of your race **or** you have other evidence of discrimination, you should check (✓) **RACE**. If you feel the adverse treatment was due to multiple reasons, such as your sex, religion and national origin, you should check all three. If you complained about discrimination, participated in someone else's complaint or if you filed a charge of discrimination and a negative action was threatened or taken, you should check (✓) **RETALIATION**.*

Race Sex Age Disability National Origin Color Religion Retaliation
Pregnancy

Other reason (basis) for discrimination (Explain). _____

5. What happened to you that you believe was discriminatory? Include the date(s) of harm, action(s) and include the name(s) and title(s) of the persons who you believe discriminated against you. (Example: 10/02/06 – Written Warning from Supervisor, Mr. John Soto)

A) Date: _____ Action: _____

Name and Title of Person(s) Responsible: _____

B) Date: _____ Action: _____

Name and Title of Person(s) Responsible _____

Describe any other actions you believe were discriminatory.

(Attach additional pages if needed to complete your response.)

6. What reason(s) were given to you for the acts you consider discriminatory? By whom? Title?

7. Name and describe others who were in the same situation as you. Explain any similar or different treatment. Who was treated worse, who was treated better, and who was treated the same? Provide race, sex, age, national origin, religion, and/or disability status of comparator if known and if connected with your claim of discrimination. Add additional sheets if needed.

Full Name

Job Title

Description

1. _____

2. _____

3. _____

Answer questions 8-10 only if you are claiming discrimination based on disability. If not, skip to question 11.

8. Please check all that apply:

Yes, I have an actual disability

I have had an actual disability in the past

No disability but the organization treats me as if I am disabled

9. If you are alleging discrimination because of your disability, what is the name of your disability? How does your disability affect your daily life or work activities, e.g., what does your disability prevent or limit you from doing, if anything? (Example: lifting, sleeping normally, breathing normally, pulling, walking, climbing, caring for yourself, working, etc.).

10. Did you ask your employer for any assistance or change in working condition because of your disability? YES NO

Did you need this assistance or change in working condition in order to do your job? YES NO

If "YES", when? _____ To whom did you make the request? Provide full name of person _____ How did you ask (verbally or in writing)? _____ Describe the assistance or change in working condition requested?

11. Are there any witnesses to the alleged discriminatory incidents? If yes, please identify them below and indicate what they will say. Add additional pages if necessary.

	NAME	JOB TITLE	ADDRESS & PHONE NUMBER
A.	_____	_____	_____

	NAME	JOB TITLE	ADDRESS & PHONE NUMBER
B.	_____	_____	_____

	NAME	JOB TITLE	ADDRESS & PHONE NUMBER
C.	_____	_____	_____

12. Have you filed a charge previously in this matter with EEOC or another agency? YES NO

13. If you have filed a complaint with another agency, provide name of agency and date of filing:

Signature

Today's Date

If you have not heard from an EEOC office within 30 days of mailing this form, please call toll-free number shown on the letter accompanying this form. Provide the tracking number on the attached cover letter. Please make a copy of this form for your records before mailing.

PRIVACY ACT STATEMENT: This form is covered by the Privacy Act of 1974: Public Law 93-579. Authority for requesting personal data and the uses thereof are:

1. **FORM NUMBER/TITLE/DATE.** EEOC Intake Questionnaire (10/2006).
2. **AUTHORITY.** 42 U.S.C. § 2000e-5(b), 29 U.S.C. § 211, 29 U.S.C. § 626. 42 U.S.C. 12117(a)
3. **PRINCIPAL PURPOSE.** The purpose of this questionnaire is to solicit information in an acceptable form consistent with statutory requirements to enable the Commission to act on matters within its jurisdiction. When this form constitutes the only timely written statement of allegations of employment discrimination, the Commission will, consistent with 29 CFR 1601.12(b) and 29 CFR 1626.8(b), consider it to be a sufficient charge of discrimination under the relevant statute(s).
4. **ROUTINE USES.** Information provided on this form will be used by Commission employees to determine the existence of facts relevant to a decision as to whether the Commission has jurisdiction over allegations of employment discrimination and to provide such charge filing counseling as is appropriate. Information provided on this form may be disclosed to other State, local and federal agencies as may be appropriate or necessary to carrying out the Commission's functions. Information may also be disclosed to respondents in connection with litigation.
5. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION.** The providing of this information is voluntary but the failure to do so may hamper the Commission's investigation of a charge of discrimination. It is not mandatory that this form be used to provide the requested information.

ADA QUESTIONNAIRE

Name: _____

Date: _____

1. Name and describe your physical or mental condition(s).

2. How does this medical condition affect you?

3. How long have you had your condition? _____

4. Has your condition been diagnosed? _____

5. If so, when was your condition first diagnosed? _____

6. Do you know how long this condition is expected to last? Yes _____ No _____

If yes, how long? _____

7. Please describe any limitations or impact that your mental or physical condition has on your ordinary daily activities.

These can include walking, standing, sitting, eating, lifting, reaching, sleeping, speaking, breathing, seeing, learning, caring for oneself, hearing, thinking, concentrating, controlling bodily waste, relating and getting along with others, reproduction or sexual relations, performing manual tasks, etc.

8. Identify any limitations or restrictions which have been placed on you by a physician for reasons related to your condition(s).

9. Have you used any medications or assistive devices (hearing aids, canes, prosthesis) to help control or eliminate symptoms or limitations of your condition?

If so,

- (a) name and describe the assistive devices used.
- (b) list all medications taken to control or eliminate symptoms or limitations of your condition(s).
- (c) describe how well the medication and/or assistive devices controls your symptoms (at the time of the alleged discrimination).
- (d) Describe any side effects to the medications and/or assistive devices.

10. Did you notify your employer of your mental or physical condition(s)? _____
11. Indicate who was made aware of your condition(s) and when they were made aware.

<u>Name</u>	<u>Position</u>	<u>Approximate Date Notified</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. Have you asked for a reasonable accommodation from your employer (anything to help you perform your job, e.g. modification of equipment, change in job duties, schedule change, etc.)? Yes _____ No _____

If yes, describe the circumstances, including the following:

- a. Approximate date of request(s):

- b. Who did you ask for an accommodation?

- c. What accommodation did you ask for?

- d. Why did you need a reasonable accommodation? _____

- e. What was the employer's response?

