



City of Spokane

Public Accommodation Intake Questionnaire

PLEASE NOTE, BEFORE YOU PROCEED:

The City of Spokane has no jurisdiction over certain services or entities including but not limited to: police action, the decisions of courts, city or county commissions, or other administrative or licensing agencies; Internet sites; the denial of public benefits; child support; court ordered visitation; prison and jails and their inmate programs; child or adult protective services actions; Native American tribes; and the federal government.

The City of Spokane has no jurisdiction over claims that did not occur within the Spokane municipal boundaries. Your complaint will not be accepted for investigation if it falls into one of the exceptions above, or does not meet jurisdictional requirements of Title 18.

Mail Form To:

City of Spokane
Neighborhood & Business Services Division
808 W. Spokane Falls Blvd.
Spokane, WA 99201

Answer all questions as completely as possible. Limit attachments to only the requested information pertaining to your claim. You will have the opportunity to provide additional documentation if necessary at a later date.

1.) Personal Information

Last Name _____ First Name _____ MI _____

Street/Mailing Address _____ Apt. or Unit # _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email Address _____

Date of Birth ____/____/____ Gender: Male ____ Female ____ Do you have a disability? Yes__ No__

What is your race? (*Check all that apply*)

____ Hispanic ____ Caucasian ____ American Indian ____ Black ____ Native Hawaiian

____ Latino ____ Alaskan Native ____ African-American ____ Pacific Islander

What is your National Origin (country of origin or ancestry)? _____



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Do you currently qualify for refugee status as defined by USC § 1101 (a)(4), and SMC 18.01.030(v)?

_____ Yes _____ No

If we are unable to contact you, please provide a name of a person **who does not live with you** so we may contact them on your behalf;

Name _____ Relationship _____

Address _____ Apt. or Unit # _____

City _____ State _____ Zip _____

Phone _____ Email _____

2.) Organization Contact Information (If you believe that more than one organization discriminated against you, please fill out an additional Intake Questionnaire).

Organization name _____

Address _____ City _____

State _____ Zip _____ Phone _____

Type of Business _____

What is your relationship to the business? (Example; customer, patient, student, etc.) _____

What is the reason (basis) for your claim of discrimination? (*Check all that apply*)

_____ Creed/Religion _____ National Origin _____ Disability _____ Sex _____ Race

_____ Sexual Orientation/Gender Identity _____ Pregnancy _____ Retaliation

_____ Refugee Status

_____ Use of a white cane, trained dog guide or service animal by a person with a disability

If you checked Religion or National Origin or Refugee Status, please specify: _____



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3.) Complaint Information

Please describe how you believe you were discriminated against.

Include the date(s) of harm, the action(s) and the names and title(s) of the person(s) who you believe discriminated against you. Please attach additional pages if needed.

Date: _____ Action: _____

Name & Title of Person(s) Responsible:

Date: _____ Action: _____

Name & Title of Person(s) Responsible:

Why do you believe these actions were discriminatory? _____

What reason(s) were you given for the acts you consider discriminatory? _____

By whom? _____ Job Title: _____

Have you already filed a complaint in this matter? _____ Yes _____ No

Provide name of agency and date of filing: _____

Results? *(If any)* _____

Have you sought help about this situation from anyone? _____ Yes _____ No

Provide name of organization/person you have contacted for help and date of contact: _____



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Results? *(If any)* _____

4.) Discrimination Based on Disability

Are you disabled? *(Check all that apply)*

_____ Yes, I am a person with a disability.

_____ I am not a current person with a disability, but I was previously.

_____ No disability, but the organization believes I am a person with a disability.

What is the disability? _____

Does this disability limit you from doing anything? *(Example: lifting, sleeping, breathing, walking, working...etc.)*

Do you have a service animal? _____ Yes _____ No

What type of service animal and what service does it provide? _____

This is the end of the Public Accommodation Intake Questionnaire. Please review all pages.

I declare under penalty of perjury under the laws of the State of Washington that I have read the foregoing and that it is true and correct.

Complainant's Signature

Date