COMPLAINT/ RESPONSE

SECTION I – COMPLAINT INFORMATION: Your complaint must be submitted to the Commission Secretary, along with any written documentation you consider appropriate, within 7 calendar days of the incident which is the basis of your complaint. If your complaint involves a disciplinary action, the complaint must be filed within the earlier of (i) seven (7) calendar days of your receipt; or (ii) ten (10) calendar days of the County and/or District's deposit in the mail; or written notice of the disciplinary action taken against you. If the disciplinary action involves a disciplinary suspension without pay, involuntary demotion or dismissal. DO NOT USE THIS FORM. Instead, you should use the HCCS Form 2 to file a grievance with the Commission on disciplinary suspensions without pay, involuntary demotions or dismissals.

<table>
<tr><td rowspan="2">Name and Address of Employee Filing Complaint</td><td>Social Security Number</td><td rowspan="2">Date of Incident</td></tr>
<tr><td>XXX-XX-</td></tr>
<tr><td rowspan="2"></td><td>Telephone Number (s)</td><td rowspan="2"></td></tr>
<tr><td>Home:
Office:
Cell:</td></tr>
<tr><td>County and/or District Department where employed</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Name and Address of Employee Representative (if applicable)</td><td>Telephone Number (s)</td><td rowspan="2"></td></tr>
<tr><td>Office:
Cell:
Fax:</td></tr>
</table>

SUMMARY OF COMPLAINT, INCLUDING SPECIFIC COMMISSION RULE OR RULES VIOLATED: (Use extra sheets of paper if necessary to fully explain your complaint).

I request an □ open □ closed (check one box) hearing.

REMEDIAL ACTION REQUESTED: (Use extra sheets of paper if necessary to fully explain the relief you seek).

Signature – Employee Date

HCCS FORM – 1 should be used for Employee Complaints filed on or after January 1, 1996.

ELECTED OFFICIAL/DEPARTMENT HEAD RESPONSE

SECTION II – ELECTED OFFICIAL DEPARTMENT HEAD REVIEW: The Elected Official/Department Head meets with the employee to discuss the complaint; gathers information; enters a response below and meets with the employee to discuss the response – all generally within 14 calendar days after the Elected Official/Department Head receives the employee's complaint from the Commission Secretary. The Elected Official/Department Head records his or her response to the employee's complaint on the original of this HCCS Form – 1 and returns the original, signed form, to the Commission Secretary.

Name and Address of Elected Official/Department Head	*Date Complaint Received from Commission Secretary*	*Date of EO's/Dept Head's Review Decision*
Name and Address of Elected Official/ Dept. Head Representative (if applicable)	*Telephone Number*	
	Office: *Cell:* *Fax:*	

SUMMARY OF ELECTED OFFICIAL'S/DEPARTMENT HEAD'S RESPONSE: (Use extra sheets of paper if necessary to fully explain your decision).

Signature – Elected Official/Department Head Date

EMPLOYEE RESPONSE TO SECTION II

SECTION II (CONTINUED) EMPLOYEE RESPONSE: The employee either accepts or appeals the above response of the Elected Official/Department Head by checking the appropriate box, signing this form, and returning the original of this form to the Commission Secretary within the earlier of: (i) seven (7) calendar days of the employee's receipt, or (ii) ten (10) calendar days of the deposit in the mail; of the Elected Official's/Department Head's decision from the Commission Secretary. Failure to return the completed form is presumed to be an acceptance of the Elected Official's/Department Head's decision.

□ I accept the response.

□ I appeal the response and if the Commission grants me a hearing, I want the hearing to be:

□ OPEN □ CLOSED (Check one box) to the public.

PLEASE LIST IN THE COMMENTS ANY SPECIAL ACCOMODATIONS YOU REQUIRE IF A HEARING IS GRANTED, SUCH AS AN INTERPRETER.

COMMENTS: (Use extra sheets of paper if necessary to fully explain your comments.)

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Signature – Employee Date

HEAD START POLICY COUNCIL RESPONSE

SECTION III – REVIEW BY HEAD START POLICY COUNCIL WHEN EMPLOYEE COMPLAINT INVOLVES A HEAD START PROGRAM EMPLOYEE: If a Head Start Program employee appeals the response of the Elected Official/Department Head, the Commission Secretary forwards the original of this form to the Head Start Program Director who forwards it to the Head Start Policy Council. The Council enters its response in Section III of this form and returns the original HCCS Form 1 to the Commission Secretary.

Name and Address of Head Start Policy Council Chairperson	*Date Complaint Received by Head Start Program Director from Commission Secretary*	*Date Complaint Received by Policy Council for Action*

SUMMARY OF HEAD START POLICY COUNCIL RESPONSE: (Use extra sheets of paper if necessary to fully explain your decision).

Signature – Head Start Program Policy Council Chairperson Date

EMPLOYEE RESPONSE TO SECTION III

SECTION III (CONTINUED) EMPLOYEE RESPONSE: The employee accepts or appeals the above response of the Head Start Policy Council by checking the appropriate box, signing this form, and returning the original of this form to the Commission Secretary within the earlier of: (i) seven (7) calendar days of the employee's receipt, or (ii) ten (10) calendar days of the deposit in the mail; of the Head Start Policy Council decision from the Commission Secretary. Failure to return the completed form is presumed to be an acceptance of the Head Start Policy Council's decision.

□ I accept the response.

□ I appeal the response and if the Commission grants me a hearing, I want the hearing to be:

□ OPEN □ CLOSED (Check one box) to the public.

PLEASE LIST IN THE COMMENTS ANY SPECIAL ACCOMODATIONS YOU REQUIRE IF A HEARING IS GRANTED, SUCH AS AN INTERPRETER.

COMMENTS: (Use extra sheets of paper if necessary to fully explain your comments.)

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Signature – Employee Date

SECTION IV - FINAL REVIEW BY HEAD START POLICY COUNCIL: If the Commission reverses a decision of the Head Start Policy Council, the Commission Secretary forwards the original of the HCCS Form 1 to the Head Start Program Director, who forwards it to the Head Start Policy Council. The council enters its response in this Section IV and returns the original of this HCCS Form 1 to the Commission Secretary.

Name and Address of Head Start Policy Council Chairperson	*Date Complaint Received by Head Start Program Director from Commission Secretary*	*Date Complaint Received by Policy Council for Action*

SUMMARY OF HEAD START POLICY COUNCIL RESPONSE: (Use extra sheets of paper if necessary to fully explain your decision).

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Signature – Head Start Program Policy Council Chairperson Date