Discrimination American with Disabilities Act (ADA) Complaint Form

Section I:		
Name:		
Address:		
Telephone (Home):	Telephone (Work):	
Electronic Mail Address:		
Accessible Format Requirements?	☐ Large Print	☐ Audio Tape
	☐ TDD	☐ Other

Section II:		
Are you filing this complaint on your own behalf?	☐ Yes*	☐ No
If you answered "yes" to this question, go to **Section III.*		
If not, please supply the name and relationship of the person for whom you are complaining.		
Please explain why you have filed for a third party:		
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.	☐ Yes	☐ No

Section III:

If you believe you were discriminated against based on a disability, please provide as much detail concerning the alleged discrimination.

Date of Alleged Discrimination (Month, Day, Year): _____

Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. Any details related to time of day, transit route/line, vehicle ID or Name. If more space is needed, please use the back of this form.

_____

_____

Section VI:		
Have you previously filed a Discrimination Complaint with this agency?	☐ Yes	☐ No

If yes, please provide any reference information regarding your previous complaint.

_____

_____

Section V:

Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court?

☐ Yes ☐ No

If yes, check all that apply:

☐ Federal Agency: _____

☐ Federal Court: _____ ☐ State Agency: _____

☐ State Court: _____ ☐ Local Agency: _____

Please provide information about a contact person at the agency/court where the complaint was filed.

Name:

Title:

Agency:

Address:

Telephone:

Section VI:

Name of agency complaint is against:

Name of person complaint is against:

Title:

Location:

Telephone Number (if available):

You may attach any written materials or other information that you think is relevant to your complaint. Your signature and date are **required** below:

_____ _____

Signature Date

Please submit this form in person at the address below, or mail this form to:
Adams County Council on Aging
Michelle L Lengerich, Executive Director
1109 Dayton Street, Room 1, Decatur, IN 46733
260-724-5316
coadirector@co.adams.in.us
A copy of this form can be found online at **www.adamscountycouncilonaging.org**
If you need assistance completing this form contact Michelle L Lengerich.

ADA Complaint Process

In compliance with the U.S. Department of Transportation Americans with Disabilities Act (ADA) of 1990 (49 CFR Parts 27, 37, 38 and 39), and Section 504 of the Rehabilitation Act of 1973, as amended, **ADAMS COUNTY COUNCIL ON AGING** ensures its services, vehicles, and facilities are accessible to and usable by individuals with disabilities. Anyone who believes he or she has been discriminated against on the basis of disability may file an ADA complaint.

Complaints may be submitted by filing a Customer Service Report/ADA Complaint Form online, by downloading an ADA Complaint Form at INSERT WEBSITE ADDRESS HERE or by calling INSERT PHONE NUMBER HERE (TTY/TDD TTY Phone #). If the complainant is unable to write a complaint, a representative may file on his or her behalf, or **ADAMS COUNTY COUNCIL ON AGING** staff will provide assistance. Complaints must be filed within 180 calendar days of the alleged incident.

1. The Adams County Council on Aging Executive Director will contact the complainant within 10 business days of receipt of complaint. Any requested information must be received by **ADAMS COUNTY COUNCIL ON AGING** within 5 days of request*.
2. **ADAMS COUNTY COUNCIL ON AGING** will begin the investigation within 15 business days of receipt of complaint if the alleged discrimination is found to be a violation of ADA regulations.
3. An investigation into the complaint will be conducted and documented to determine whether **ADAMS COUNTY COUNCIL ON AGING** failed to comply with ADA regulations.
4. **ADAMS COUNTY COUNCIL ON AGING** will complete the investigation within 60 calendar days of receipt of complaint. If additional time is needed for the investigation, the complainant will be notified.
5. **ADAMS COUNTY COUNCIL ON AGING** will promptly communicate its response to the complainant, including its reasons for the response. The complainant will have 5 business days from receipt of **ADAMS COUNTY COUNCIL ON AGING** response to file an appeal. If no appeal is filed, the complaint will be closed. **ADAMS COUNTY COUNCIL ON AGING** process and investigate all complaints that meet the requirements of ADA discrimination. If the complainant fails to provide required information within the required timeframe, the complaint may be closed.