

Title II of the Americans with Disabilities Act Complaint / Grievance Form

Larimer County, Colorado

Introduction

This grievance form is solely for facilities, activities, programs and services owned and/or operated by Larimer County, Colorado.

If you are a county employee or job applicant wishing to file a complaint of disability discrimination, do not use this form. The county's personnel policies and procedures govern employment related complaints of disability discrimination.

If your grievance is related to a non-County owned business (Title III businesses), please contact the U.S. Department of Justice Information Line at [1-800-514-0301](tel:1-800-514-0301) for assistance.

Instructions

Please print clearly or type your answers, if possible. If you need help due to your disability in completing this grievance form, you may contact the ADA Coordinator at accessibility@larimer.org or at Telephone No. [\(970\) 498-5967](tel:970-498-5967)

Submit your Grievance Form using one of the following options:

1. By email to: accessibility@larimer.org
2. By U.S. Mail to:

Donna J. Notter
Larimer County ADA Coordinator
200 West Oak Street, Suite 4000
PO Box 1190
Fort Collins, CO 80522-1190

3. You may also complete this form online at the following web address:
<https://www.larimer.org/ada-grievance-form>

Your information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Work): _____ (Cell): _____

(TTY): _____ Email: _____

Check all preferred methods of communication:

Voice Telephone TTY CRS Email U.S. Mail Other: _____

What is your relationship to the complainant?

Self Family member/guardian Advocate Other: _____

Are you filing this grievance on behalf of someone else?

If so, please enter their information here:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Work): _____ (Cell): _____

(TTY): _____ Email: _____

Check all preferred methods of communication:

Voice Telephone TTY CRS Email U.S. Mail Other: _____

Complaint Information

Who Your Complaint is Against?

County Employee and / or County Department

Name: _____ Job Title: _____

County Department: _____

Address: _____ Telephone: _____

Primary type of disability:

- Cognitive/intellectual / Developmental
- Learning
- Mental/psychiatric
- Vision
- Hearing
- Seizure
- Speech
- HIV/AIDS
- Diabetes
- Other: _____

Nature of Complaint:

- Denial of services or benefits/refusal to admit
- Failure to reasonably accommodate
- Physical access
- Sign language interpreter/assistive listening
- Service animal
- Retaliation
- Other: _____

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Description of Complaint (please describe fully the nature of your complaint):

Description of Complaint (Continued):

Witness Information

If other people witnessed the incident, please list their names and contact information here

Name: _____ Job Title (if County employee): _____

Address: _____

Telephone number/email/other contact information: _____

Name: _____ Job Title (if County employee): _____

Address: _____

Telephone number/email/other contact information: _____

Evidence and Documentation

Please list and provide any physical evidence, written or recorded documents, or any other information that directly supports your specific claim. You may also attach photographs or other documents in support of your claims.

1. _____
2. _____
3. _____
4. _____

What actions would you want the County to take in response to your complaint?

This form should be submitted to the ADA Coordinator as soon as possible, but no later than 90 calendar days after the alleged violation.

I certify that to the best of my knowledge this information is true and correct.

Signature: _____ Date: _____

Parent or Legal Guardian may sign on behalf of minor child. Legal Guardian, Power of Attorney or equivalent may sign on behalf of adult – documentation is required.

For Administrative Use Only

ADA Coordinator Signature

Date Received