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 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

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-grievience-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):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

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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