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:

   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

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

Larimer County, Colorado

Your Information

Name:____

Address:____

City:______________________________State:__________Zip:____________

Telephone (Home):__________(Work):______________(Cell): ______________

(TTY):____________________Email: _________________________

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: _________________________

What is your relationship to the complainant?

☐ Self ☐ Family member/guardian ☐ Advocate ☐ Other: ____________

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 fully describe the nature of your complaint):

____

____

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____

Description of Complaint (Continued):

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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?

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____

This form should be submitted to the ADA Coordinator as soon as possible, but no later than 60 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.

This Section for Administrative Use Only

____________________________________ ______________________

ADA Coordinator Signature Date Received