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
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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):
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
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 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