Auglaize County Council on Aging
ADA Complaint Resolution Form – Disability-Related Grievance

Complainants' Full Name: _____

Mailing Address: _____

Phone number where individual can be reached: _____

Complainant's Status: ___Client ____ Interested Party ___ Employee ___Job Applicant

Name of person you believe discriminated against you: _____

Place of incident: _____

Date: _____ Time: _____

Statement: Please describe the incident as clearly and concisely as possible. Proved as much detail as you can recall. Explain why you believe the conduct or treatment was discriminatory. Use additional paper, if necessary. Also, please attach any documents or material you believe are relevant.

Did anyone witness the incident: If so, please list names and phone numbers of witnesses. Use additional paper, if necessary.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Action Sought: Please describe what you would like to see done to correct the situation.

I agree that this statement of allegations may be used during the investigation of this case. I further consent that this statement and certain information in the complaint file may be disclosed to certain agency employees including the person who is being named in the complaint as having committed the alleged discriminatory act in order to resolve the complaint, conduct fact finding, or implement remedial action. I also understand that information may be disclosed if required by law, rule, regulation or court order. I affirm that this complaint statement is true, accurate, and complete to the best of my knowledge.

_____ _____

Signature of Complainant Date

All complaints will be forwarded to the Ohio Department of Transportation