



## ADA COMPLAINT FORM

This complaint procedure is designed to resolve conflicts involving allegations of discrimination in access to Claiborne County Human Resource Agency Public Transit programs, services, and activities for persons with disabilities under the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973.

<b>Section I:</b>				
Name:				
Address:				
Telephone (Home):			Telephone (Work):	
<b>Do you require a reasonable accommodation in order to more effectively communicate your complaint?</b>				
Accessible Format Requirements?	Large Print		Audio Tape	
	TDD		Other	
<b>Section II:</b>				
Are you filing this complaint on your own behalf?			Yes*	No
*If you answered "yes" to this question, go to Section III.				
If not, please supply the name and relationship of the person for whom you are complaining:				
Please explain why you have filed for a third party: _____				
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.			Yes	No
<b>Section III:</b>				
Date of Alleged Discrimination (Month, Day, Year): _____				
Explain as clearly as possible what happened and why you believe you were discriminated against. <b>Identify service, program or activity out of ADA/504 compliance.</b> Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please use the back of this form.				
_____				
_____				


<b>Section IV</b>		
Have you previously filed an ADA complaint with this agency?	Yes	No

<b>Section V</b>
<p>Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Federal Agency: _____</p> <p><input type="checkbox"/> Federal Court _____                      <input type="checkbox"/> State Agency _____</p> <p><input type="checkbox"/> State Court _____                      <input type="checkbox"/> Local Agency _____</p>

Please provide information about a contact person at the agency/court where the complaint was filed.
Name:
Title:
Agency:
Address:
Telephone:

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date required below

\_\_\_\_\_

Signature Date  
Please submit this form in person at the address below, or mail this form to:

**Jerome Williams**  
**ADA COORDINATOR/TRAINER**  
**CLAIBORNE COUNTY HUMAN RESOURCE AGENCY**  
**1703 Bridewell Lane Port Gibson, MS 39150**