ADA GRIEVANCE PROCEDURE FORM
ALLEGED DISCRIMINATION DUE TO DISABILITIES

If you need to request an accommodation please use REQUEST FOR ACCOMMODATION FORM.

If you believe that you were denied accommodation to a County facility, program or service due to a disability, please complete this form and submit to:

St. Charles County Human Resources
ADA Coordinator
201 N. Second St. Room 519
St. Charles, MO 63301

If you need assistance in completing this form or an alternative format, please contact the ADA Coordinator in Human Resources at (636) 949-7320.

Complainant Contact Information

NAME _____ ADDRESS LINE 1 _____

WORK PHONE _____ PERSONAL PHONE (CELL OR HOME) _____ ADDRESS CITY, STATE, ZIP _____

E-MAIL _____ PREFERRED METHOD OF CONTACT _____

Accessibility Issue

Please answer the following questions as completely as possible. The person designated as the ADA Coordinator will contact you within 15 days of receipt of this form to discuss.

FACILITY, DEPARTMENT, PROGRAM, OR SERVICE ALLEGED TO BE INACCESSIBLE _____

WHEN DID THE SITUATION OCCUR? (DATE) _____ NAME OF STAFF _____

Describe the situation or way in which the facility, department, program or service is not accessible.

_____
_____
_____
_____

Have you contacted anyone in the Department involved to resolve this issue directly with staff of the facility, program or service? _____ NO _____ YES, Date _____
Did you file a formal written complaint? _____ NO _____ YES
Did you talk with a staff member? _____ NO _____ YES
If yes, who did you provide written complaint or whom did you speak: _____
_____

If you tried to resolve the matter directly with the staff of the facility, program or service what were the results of your contact? _____
_____
_____
_____
_____

Have you filed a FORMAL complaint about this with any other government agency?
_____ NO _____ YES, List name of the agency: _____

How do you suggest this issue be resolved? _____
_____
_____
_____
_____

_____ _____
Signature Date