

ADA or TITLE VI COMPLAINT FORM

Please check one of the above boxes

| | | | |
|---|---|---|---------------------|
| Section I: | | | |
| Name: | | | |
| Address: | | | |
| Telephone (Home/Cell): | | Telephone (Work): | |
| Email Address: | | | |
| Accessible Requirements? | Format None <input type="checkbox"/> | Large Print TDD | Audio Tape Other |
| Section II: | | | |
| 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 |
| Section III: | | | |
| I believe the discrimination I experienced was based on (check all that apply): | | | |
| <input type="checkbox"/> Race <input type="checkbox"/> Color <input type="checkbox"/> National Origin <input type="checkbox"/> My Disability <input type="checkbox"/> Other | | | |
| Date of Alleged Discrimination (Month Day, Year) _____ | | | |
| Explain as clearly as possible what happened and why you believe you were discriminated against. 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. | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| Section IV | | | |
| Have you previously filed an ADA and/or Title VI complaint with this agency? | | Yes | No |
| Section V | | | |
| Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If yes, check all that apply: | | | |
| <input type="checkbox"/> Federal Agency: _____ | | | |
| <input type="checkbox"/> Federal Court _____ | | <input type="checkbox"/> State Agency _____ | |
| <input type="checkbox"/> State Court _____ | | <input type="checkbox"/> Local Agency _____ | |

| |
|--|
| Please provide information about a contact person at the agency/court where the complaint was filed. |
| Name: |
| Title: |
| Agency: |
| Address: |
| Telephone: |
| Section VI |
| Name of agency complaint is against: |
| Contact person: |
| Title: |
| Telephone number: |

Important Notice: To protect your rights, your complaint must be filed within 180 days following the date of the alleged discrimination. Failure to file within 180 days may result in dismissal of the complaint. You may attach any additional written materials or other information that you think is relevant to your complaint to this form.

Signature and date required below

Signature of Person Filing Complaint

Date

If information is needed in another language, contact Sonja Trbovich, Transit Director (330) 627-1900.

Please submit this form to:

Carroll County Title VI Coordinator
Board of Carroll County Commissioners
119 S. Lisbon Street, Suite 201
Carrollton, OH 44615
(330) 627-4869
mschaar@carrollcountyohio.us