

AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Today's Date: _____

Name of Grievant: _____

Address of Grievant: _____

Telephone Number of Grievant: _____

Name, Address, and Telephone Number of Alternate Contact

Person: _____

Agency alleged to have denied access:

Department: _____

Division: _____

Bureau or Office: _____

Location: _____

I was denied access on: _____ [date]

I requested an accommodation on _____ [date]

The person I requested an accommodation from was: _____

I was denied an accommodation.

Disability Statement:

My disability is: _____

This problem is: temporary _____ permanent _____

I am seeking access to the following Harris County program or activity in which I haven't been able to participate because I need an accommodation: _____

Proposed Access or Accommodation: _____

The accommodation I seek

is: _____

Incident or Barrier:

Please describe the particular way in which you believe you have been denied the benefits of any services, program, or activity or have otherwise been subjected to discrimination. Please specify dates, times, and places of incidents, and names and/or positions of agency employees involved, if any, as well as names, addresses and telephone numbers of any eyewitnesses to any such incident. Attach additional pages if necessary. Include a description of the way in which you feel access may be had to the benefits described above, or the way in which accommodation could be provided to allow access.

Fax or email to: ADA Coordinator, Harris County HRRM, 1310 Prairie, Suite 230, Houston, Texas 77002,
713-274-5426 (Fax) or email: HRRMHCADACoordinator@bmd.hctx.net.