

## AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM FOR ACCESS/PARTICIPATION IN FACILITIES, PROGRAMS, AND SERVICES

Today's Date:
Name of Grievant:
Address of Grievant:
Telephone #:
Name, Address, Telephone # of Grievant Representative:
Please fill out the following questions regarding your complaint against the County facility, program or service. If you have any questions or need assistance in filling out this form, please contact The County of El Paso, Human Resources Office ADA Coordinator (915) 546-2218 or amanning@epcounty.com.
1. I was denied access or services on:
(Date):
2. Department or facility (address of buildings or parks) alleged to have denied access, service, or was inaccessible.
3. I'm seeking access to the following: Facility Program Service Activity
4. I need:
An Accommodation (for an activity, program, or service, example: need large print documents)
A Modification (for a building or park, example: building needs a ramp)



4. Please describe the particular way in which you believe you have been denied access to Cou Paso facilities and/or participation in any County of El Paso service, program, or activity otherwise been subjected to discrimination. Please specify dates, times, and places of incid names and/or positions of agency employees involved, if any, as well as names, addre telephone numbers of any eyewitnesses to any such incident. Attach additional pages if neces	or have lents, and esses and
5. Describe the way in which you feel participation may be accomplished to the benefits describ or the way in which accommodation could be provided to allow access:	ed above,

Deliver, Mail, or Fax this form to:

County of El Paso ADA Coordinator 500 E. Overland El Paso, TX 79901 Phone: 915-546-2218

Phone: 915-546-221 Fax: 915-546-8126