ADA COMPLAINT FORM

ACTS must assure that no qualified individual shall, on the basis of their disability, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any of its programs, service or activities as provided by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

Any person believing they have been discriminated against based on disability should complete this ADA Complaint Form. Once completed, please submit this form to ACTS by mail to 701 N. Mercer St, New Castle, PA 16101, by email to actscs@lccap.org, or by fax to (724) 546-5160.

This complaint form is to be used only to lodge complaints in which you feel your rights were violated under the Americans with Disabilities Act (ADA). For complaints that do not allege disability discrimination, please contact ACTS Customer Service at (724) 652-5588 to file the appropriate complaint form.

SECTION 1

Name: ______________________________

Address: ______________________________

Phone (Home): ____________________ Phone (Cell): ____________________

E-Mail Address: ______________________________

Accessible Format Requirements? (Please Check, If Applicable):	Large Print ________	Audio Tape ________
	TDD ________	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 you answered "NO" to this question, please complete this section:*

If not, please supply the name and relationship of the person for whom you are lodging this complaint:		
Please explain why a third party is filing this complaint:		
Please confirm that you have obtained permission from the person for whom this complaint is being filed on their behalf:	YES _____	NO _____

SECTION III

Date of Incident (Month, Day, Year): ______________________

Please describe the incident in which an allegation of disability discrimination is being made. Explain what happened, how you were discriminated against, and all persons who were involved. Include the name of the person(s) who discriminated against you (if known), as well as the names and contact information of any witnesses. If more space is needed, please use the back of this form. You may also attach additional pages and written materials if you feel they are relevant to your complaint.

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SECTION IV

Have you previously filed an ADA Complaint with this agency? YES ______ NO ______

If so, what is the date of your previous complaint? ______________________

SECTION V

Have you filed this complaint with a Federal, State, or Local Agency, or with any Federal or State Court?

YES ______ NO ______

If YES, check all that apply and indicate the agency/court information:

[ ] Federal Agency: ______________________

[ ] Federal Court: ______________________

[ ] State Agency: ______________________

[ ] State Court: ______________________

[ ] Local Agency: ______________________

Please provide information about the contact person at the agency/court where the complaint was filed:

Name: ______________________ Title: ______________________

Agency: ______________________

Address: ______________________

Telephone: Email:

Complaints may also be filed no later than 180 days after the date of the alleged discrimination here: //www.ada.gov/filing_complaint.htm

Signature and Date Required Below:

______________________ ______________________

Signature *Date*