



AMERICANS WITH DISABILITIES ACT (ADA) TITLE II GRIEVANCE AND COMPLAINT FORM

(Problems with Public Access to Programs, Services, or Activities)

The County of Orange ensures that no person or groups of persons shall, on the grounds of race, color, sex, religion, national origin, age, disability, retaliation, or genetic information, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any and all County programs, services, or activities administered.

Instructions: Please fill out this form completely. A printed or typed response is recommended. Sign and return to the address on next page by email, fax, mail, or in person within 60 days of the alleged incident. If you need an accommodation to complete or submit this form, please contact the respective [Department ADA Coordinator](#).

1. Grievant Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home: (_____) _____ Work:(_____) _____

Cell Phone: (_____) _____ Email Address: _____

Check all preferred methods of communication:

Voice Telephone 711 CA Relay Service Email U.S. Mail

Other: _____

2. Designated Person to Contact (If Other Than the Grievant):

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home: (_____) _____ Work:(_____) _____

Cell Phone: (_____) _____ Email Address: _____

Check all preferred methods of communication:

Voice Telephone 711 CA Relay Service Email U.S. Mail

Other: _____

3. Alleged Accessibility Issue with County of Orange Program, Service, or Activity:

Date of Alleged Incident: _____ Time of Alleged Incident: _____

Location/Address of Alleged Incident:

4. Describe The Incident/Complaint with Enough Detail so the Nature of the Grievance Can Be Understood: (Attach Additional Pages If Necessary)

5. Have Attempts Been Made to Resolve the Complaint Through a County Department? If Yes, Please Describe the Efforts That Have Been Made: (Attach Additional Pages If Necessary)

6. If the Alleged Incident Involved County Employee(s), Please List Name(s):

7. Name and Contact Information of Witness(es), If Applicable:

8. Requested Remedy for Your Grievance: (Attach Additional Pages If Necessary)

9. Evidence and Documentation: Please provide any physical evidence, written, recorded documents, or any other information that directly supports your specific allegation(s) including photographs or other documents in support of your grievance.

To The Best of My Knowledge, The Above Information and Statements Are True and Accurate:

10. Signature: _____ **Date:** _____

Please Submit Your ADA Title II Grievance Form To:

Mailing Address: [Department ADA Title II Coordinator](#)

Alternatively, you may submit the form to the County ADA Title II Manager for review and assistance with forwarding the form to the appropriate Department ADA Coordinator.

Mailing Address: ADA Title II Program
CEO Risk Management
400 W. Civic Center Drive, 5th Floor
Santa Ana, CA 92701

Voice: (714) 285-5540
7-1-1 CA Relay Service

Fax: (714) 285-5599

Email: ada@ceo.oc.gov

FOR COUNTY USE ONLY	
Received By (First & Last Name):	_____
Date Received (MM/DD/YY):	_____