Tangipahoa Parish Americans With Disabilities Act Complaint Form

Please use this form to file a complaint based on disability in the provision of services, activates, programs or benefits.

The following information is necessary to assist us in processing your complaint. If you require any assistance in completing this form, please call (985) 748-3211. The completed form must be sent to: Parish HR Department, P. O. Box 215, Amite, La. 70422-0215 or HR@tangipahoa.org.

COMPLAINTANT INFORMATION

Name: _____

First Name MI Last Name

Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Home Address: _____

City_____ State_____ Zip Code: _____

Email: _____

1. **Your Claim is made against:** _____

   Agency: _____

   Name: _____

   Title: _____

   Address: _____

   Phone: _____

2. **Location(s) and date(s) of the circumstances giving rise to your complaint:** _____

_____

_____

_____

_____

_____

Are the circumstances of your complaint continuing?

☐ Yes ☐ No

3. **Please describe the alleged denial of service, activities, programs or benefits and your reason(s) for concluding that the conduct was discriminatory. Please include the name(s) of witnesses, if any, and attach supporting data, if available.**

_____

_____

_____

_____

_____

4. **A.** Have you filed a claim regarding this complaint with a federal, state, or local government agency?
☐ Yes ☐ No If yes, who and when:_____

B. Have you hired an attorney with respect to the allegations in the complaint?
☐ Yes ☐ No If yes, who and when:_____

C. Have you instituted a legal suit or court action regarding this complaint?
☐ Yes ☐ No

5. **This complaint form was completed by:**
☐ Government Representative ☐ Complainant ☐ ADA Coordinator

I affirm that I have read the above charge and that it is true to the best of my knowledge.

Complainant's Signature: _____ Date: _____/_____/_____

OFFICE USE ONLY

HR Receive Stamp: