



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

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Today's Date: \_\_\_\_\_

Name of Grievant: \_\_\_\_\_

Address of Grievant: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Name, Address, Telephone # of Grievant Representative: \_\_\_\_\_

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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](mailto:amanning@epcounty.com).

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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.

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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)

