



# Tangipahoa Parish Americans With Disabilities Act Complaint Form

Please use this form to file a complaint based on disability in the provision of services, activities, 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: Personnel Director, P. O. Box 215, Amite, La. 70422-0215 or [vbaker@tangipahoa.org](mailto:vbaker@tangipahoa.org).

### COMPLAINANT 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:** \_\_\_\_\_

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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.**

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**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:**