COMMUNITY COUNSELING CENTER ADA COMPLAINT FORM

Community Counseling Center is committed to ensuring that no person is excluded from participation in or denied the befits of its services on the basis of ability as provided by the Americans with Disabilities Act (ADA) of 1990. ADA Complaints must be filed within 180 days from the date of the alleged discrimination.

The following information is necessary to assist us in processing your complaint. If you require any assistance in completing this form or need information in alternate formats, please let us know.

Please mail or return this form to:

Corporate Compliance Officer
Community Counseling Center
402 S. Silver Springs Road
Cape Girardeau, MO 63703
573-651-4345 fax number

PLEASE PRINT

1. Complainant's Name:
a. Address:
b. City: State: Zip Code:
c. Telephone (include area code): Home ( ) or Cell ( ) Work ( ) - ( ) -
d. Electronic mail (e-mail) address:
Do you prefer to be contacted by this e-mail address? ( ) YES ( ) NO
2. Accessible Format of Form Needed? ( ) YES specify:_____ ( ) NO
3. Are you filing this complaint on your own behalf? ( ) YES If YES, please go to question 7. ( ) NO If no, please go to question 4
4. If you answered NO to question 3 above, please provide your name and address. a. Name of Person Filing Complaint:
b. Address:
c. City: State: Zip code:
d. Telephone (include area code): Home ( ) or Cell ( ) Work ( ) - ( ) -
e. Electronic mail (e-mail) address:
Do you prefer to be contacted by this e-mail address? ( ) YES ( ) NO
5. What is your relationship to the person for whom you are filing the complaint?
6. Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party. ( ) YES, I have permission. ( ) NO, I do not have permission.
7. I believe that the discrimination I experienced was based on (check all that apply): ( ) Accessibility Issue ( ) Discrimination based on disabiity ( ) Other (please specify)

8. Date of Alleged Discrimination (Month, Day, Year):
9. Where did the Alleged Discrimination take place?
10. Explain as clearly as possible what happened and why you believe that you were discriminated against. Describe all of the persons that were involved. Include the name and contact information of the person(s) who discriminated against you (if known). *Use the back of this form or separate pages if additional space is required.*
11. Please list any and all witnesses' names and phone numbers/contact information. *Use the back of this form or separate pages if additional space is required.*
12. What type of corrective action would you like to see taken?
13. Have you filed a complaint with any other Federal, State, or local agency, or with any Federal or State court? ( ) YES If yes, check all that apply. ( ) NO a. ( ) Federal Agency (List agency's name) b. ( ) Federal Court (Please provide location) c. ( ) State Court d. ( ) State Agency (Specify Agency) e. ( ) County Court (Specify Court and County) f. ( ) Local Agency (Specify Agency)
14. If YES to question 14 above, please provide information about a contact person at the agency/court where the complaint was filed. Name: Title:
Agency: Telephone: ( ) -
Address:
City: State: Zip Code:

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date is required:

_____ _____

Signature Date

If you completed Questions 4, 5 and 6, your signature and date is required:

_____ _____

Signature Date