

**ADA COMPLAINT FORM**

Americans with Disabilities Act Complaint Form:

The County of Salem is committed to ensuring that no person is denied access to its services, programs, or activities on the basis of their disabilities, as provided by the title ii of the Americas with Disabilities Act of 1990 ("ADA"). ADA complaints must be filed within 180 days from the date of the alleged incident.

The following information is necessary to assist us in processing your complaint. If you require any assistance in completing this form, or if you would like to make a verbal complaint, please contact the Salem County Office on Aging.

Complainant: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, Sate, Zip Code: \_\_\_\_\_  
Alt. Phone: \_\_\_\_\_

Person Preparing Complaint (if different from complainant): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Please describe the alleged discriminatory incident, including the location(s), if applicable. Provide the names and titles of the County of Salem employees involved, if available.

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Have you filed a complaint with any other federal, state, or local agencies? Yes or No (circle one).  
If so, list agency/agencies and contact information below:

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Agency Contact Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code & Phone: \_\_\_\_\_

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

\_\_\_\_\_  
Complainant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or Type Name of Complainant

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Received By