**Section 1725.APPENDIX A ADA/Civil Rights Program Formal Grievance Intake Form**

ADA/Civil Rights Program Formal Grievance Intake Form

Discrimination Based on a Disability

Denial of Reasonable Accommodation Request

It is the policy of the Illinois Department on Aging to provide assistance in filling out these forms. If assistance is needed, please ask:

ADA/Civil Rights Program Coordinator

Illinois Department on Aging

421 East Capitol Avenue, #100

Springfield IL 62701-1789

217/785-3346 (Voice) or 888/206-1327 (TTY)

Contact Information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City, State and Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Voice) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (TTY) Fax No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Means and Time for Contacting:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alleged Discrimination

Please fill out this part if you were excluded from participation in, or denied the benefits of, any program, service, or activity of the Department on the basis of a disability or have been subject to discrimination by the Department under federal and State civil rights laws based on classification characteristics such as age; ancestry, citizenship, color, national origin or race; creed or religion; disability; familial status, gender, sex, or sexual orientation; military status or unfavorable discharge from military service; or retaliation for having opposed an unlawful practice. A response must be provided for each line in order for the Department to take action. You may attach additional sheets for your responses, if necessary. Do not submit an incomplete form.

Program, Service, or Activity to which Access was Denied or in which Alleged Discrimination Occurred:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Alleged Discrimination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nature of Alleged Discrimination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(OVER)

(BACK OF FORM)

Reasonable Accommodation Requests

Please fill out this part if your reasonable accommodation was denied. Reasonable accommodations could include such things as providing auxiliary aids and devices and changing some policies and/or requirements to allow a qualified individual with a disability to participate in any program, service, or activity of the Department. You may attach additional sheets for your responses, if necessary. A response should not be provided for any line that you do not know the answer.

Exact Nature of Disability:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please attach a signed statement from a physician currently licensed to practice in Illinois.)

Reasonable Accommodation Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date the Reasonable Accommodation was Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to whom the Request was Made:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Denial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated Cost of Accommodation (if an assistive device, such as a TTY or optical reader, or commodity or service for which a cost is readily known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why is the Requested Accommodation Necessary to Use or Participate in the Program, Service, or Activity?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative Accommodations that may Provide Accessibility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Other Information You Believe Will Aid in a Fair Resolution of this Grievance:\_\_\_\_\_\_\_\_\_\_\_

Signature

I certify that I am qualified or otherwise eligible to participate in the program, service, or activity and the above statements are true to the best of my knowledge and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Please return upon completion to the ADA/Civil Rights Program Coordinator at the address listed at the top of the front page.

For Internal Use Only

Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_