

ADA Complaint Form Procedure

Background

The Americans with Disabilities Act of 1990 (ADA), provides protection that no individual with a disability shall on the basis of disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any federally funded program, service, or activity.

St. Cloud Metro Bus is committed to providing non-discriminatory service to ensure that no person is excluded from participation in, or denied the benefits of, or subjected to discrimination in the receipt of its services by providing protection that no individual with a disability shall on the basis of disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination as stated in the Americans with Disabilities Act of 1990 (ADA).

If you feel that you have been discriminated against, please provide the following necessary information to facilitate the processing of your complaint. If assistance is required to complete the form, or if you have questions, please do not hesitate to call the ADA Coordinator at 320-258-6885.

Once completed, return a signed and dated copy to:

**Missy Kraemer, Operations Manager
665 Franklin Ave NE, St. Cloud, MN 56304**

Note: The following information is necessary to assist us in processing your complaint. Should you require any assistance in completing this form, please call 320-258-6885.



ADA Complaint Form

Section I:			
Name:			
Address:			
Telephone (Home/Cell):		Telephone (Work):	
Email:			
Do you require an accessible format?	Large Print	Audio Tape	
	TTY/TDD	Other:	
Section II:			
Are you filing this complaint on your own behalf? *			Yes
*If you answered "yes" to this question, go to Section III.			No
If not, please supply the name and relationship of the person for whom you are filing:			
Have you obtained permission from this person?			Yes
No			
Section III:			
If you believe you were discriminated against based on a disability, please provide as much detail concerning the alleged discrimination.			
Date of Alleged Discrimination (Month, Day, Year): _____ Time: _____			
Transit Line/Route: _____ Vehicle ID or Name: _____ Location: _____			
Name(s) of Employee(s) involved: _____			
Explain as clearly as possible what happened and why you believe you were discriminated against. If more space is needed, please use the back of this form.			
_____ _____ _____			

Section IV		
Have you previously filed an ADA complaint with this agency?	Yes	No
Contact name:	Telephone number:	
Section V		
Have you filed this complaint with any other federal, state, or local agency, or with any federal or state court?		
[] Yes [] No		
If yes, check all that apply:		
<input type="checkbox"/> Federal Agency: _____ <input type="checkbox"/> Federal Court: _____		
<input type="checkbox"/> State Agency: _____ <input type="checkbox"/> State Court: _____		
<input type="checkbox"/> Local Agency: _____ <input type="checkbox"/> Local Court: _____		
Please provide contact information for the person you spoke to at the above agency:		
Name:	Title:	
Agency:		
Address:		
Telephone:		

Important Notice: To protect your rights, your complaint must be filed within 180 days following the date of the alleged discrimination. Failure to file within 180 days may result in dismissal of the complaint. You may attach any additional written materials or other information that you think is relevant to your complaint to this form.

Signature and date required below.

Signature of Person Filing Complaint

Date

If you need assistance completing this form, contact St. Cloud Metro Bus at 320-258-6886.

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**Missy Kraemer, Operations Manager
St. Cloud Metro Bus
665 Franklin Ave NE, St. Cloud, MN 56304**