City of Warsaw, Indiana

ADA COMPLAINT
CONSENT / RELEASE FORM

Name:	Telephone Number:
Address *(number and street, city, state, ZIP code)*	

As a complainant, I understand that during an investigation it may become necessary for The City of Warsaw to reveal my identity to individuals outside of the City of Warsaw Government in the course of verifying information or gathering facts and evidence to develop a basis for making a civil rights compliance determination. I understand that it may be necessary for the City of Warsaw to share information, including personal details collected as part of its complaint investigation. In addition, I understand that as a complainant, I am protected by Title VI of the Civil Rights Act of 1964, as amended, and its related statutes and regulations prohibiting intimidation or retaliation for taking action or participating in an action to secure rights protected by the nondiscrimination statutes enforced by the City of Warsaw.

Please read both paragraphs below, check your choice of CONSENT or CONSENT DENIED and sign below. (Please Circle One)

CONSENT _____

I have read and understand the above information and authorize the City of Warsaw to disclose my identity to individuals as needed during the course of the investigation for the purpose of verifying information or gathering facts and evidence relevant to the investigation of my complaint. I authorize the City of Warsaw to receive, review, and discuss material and information about me relevant to the investigation of my complaint.

I understand that the material and information will be used for authorized civil rights compliance and enforcement activities. I further understand that I am not required to authorize this release and volunteer to do so.

CONSENT DENIED _____

I have read and understand the above information and do not want the City of Warsaw to disclose my identity to any individual during the course of the investigation. I understand this choice could delay the investigation of my complaint and may, in some circumstances, result in an administrative closure of the investigation of my complaint without the City of Warsaw making a determination in my case.

Signature	Date:
Printed Name:	

City of Warsaw, Indiana

ADA ACCESSIBILITY COMPLAINT FORM

INSTRUCTIONS

The purpose of this form is to help any person interested in filing an ADA discrimination complaint with the City of Warsaw. You are not required to use this form. You may write a letter with the same information, sign it, and return it to the address below. All bold sections must be completed for your complaint to be investigated. Failure to provide complete information may impair the investigation of your complaint.

Upon request, assistance will be provided if you are an individual with a disability or have limited English proficiency. Complaints may also be filed using alternative formats such as computer disk, audiotape, or Braille.

Please make a copy of your complaint form for your personal records. Do not send your original documents as they will not be returned. Mail the original complaint form along with any copies of documents or records relevant to your complaint to the address below.

Complaints of discrimination must be filed within 60-days of the date of the alleged discriminatory act. If the alleged act of discrimination occurred more than 60-days ago, please explain your delay in filing this complaint. ****Your complaint cannot be processed without your signature.**

COMPLAINANT INFORMATION							
Name:							
Address (number and street, state, city, and zip code)							
Telephone Number (include area code):							
Alternate Number (include area code):							
Email Address:							
Do you need alternative accessible format for communication? If Yes, please check:							
	Large Print		Audio Tape		TTD		Other (specify):
Are you filing this complaint on your own behalf? ____ Yes _____No							
If NO - Please supply the following information of the person for whom this complaint is for:							
Name (first, middle, and last)							
Address (number and street, state, city, and zip code)							
Telephone Number (include area code):							
Alternate Number (include area code):							
Email Address:							
Do you have permission on behalf of a third-party to file a complaint? Please explain why/how:							

Continued / Claimant Name:

PERSON, ACTIVITY, AGENCY YOU BELIEVE DISCRIMINATED AGAINST YOU

Name (first, middle, and last)

Name of Company

Address (number and street, state, city, and zip code)

Telephone Number (include area code):

Alternate Number (include area code):

Email Address:

When was the last alleged discriminatory act? (month, day, year)

Complaints of discrimination must be filed within 60-days of the date of the alleged discriminatory act. If the alleged act of discrimination occurred more than 60-days ago, please explain your delay in filing this complaint.

Describe the alleged act(s) of discrimination (use additional pages, if necessary)

Provide Names Of Anyone With Additional Information Regarding Your Complaint

Witness 1 Name (first, middle, and last)

Name of Company

Address (number and street, state, city, and zip code)

Work Telephone Number ( )	Cellular Telephone Number ( )	Title

Include a brief description of the relevant information the witness may provide to support your complaint of discrimination.

Continued / Claimant Name:

Witness 2 Name (first, middle, and last)		
Name of Company		
Address (number and street, state, city, and zip code)		
Work Telephone Number ( )	Work Telephone Number ( )	Work Telephone Number ( )
Include a brief description of the relevant information the witness may provide to support your complaint of discrimination.		

Witness 3 Name (first, middle, and last)		
Name of Company		
Address (number and street, state, city, and zip code)		
Work Telephone Number ( )	Work Telephone Number ( )	Work Telephone Number ( )
Include a brief description of the relevant information the witness may provide to support your complaint of discrimination.		

How would you like your complaint to be resolved?

Have you filed a complaint alleging the same discrimination with another state or federal agency?		
○ Yes	○ No	If yes, please provide the following information for each agency:

Name of Agency	Date Complaint Filed (month, day, year)

Case Number Assigned to Your Complaint	Current Status of Your Complaint

How did you learn about your right to file a discrimination complaint with the City of Warsaw?

Signature: _____ Printed Name: _____ Date: _____

(NOTE: we cannot accept your complaint without a signature)

Please mail or return this completed form to the attention of: Justin Taylor, (ADA Coordinator), City of Warsaw, 102 S. Buffalo Street, Warsaw, IN 46580. You may also email it to jtaylor@warsaw.in.gov or by fax (574) 267-6885.