

City of Sioux Falls ADA Grievance Intake Questionnaire

1. Complainant Information: (please print)

Name: _____
First Middle (initial) Last

Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

County: _____ Daytime Phone: _____

Other Phone: _____ Date of Birth: _____
(provide only if claiming age discrimination)

Male Female Email: _____

Provide the name of someone who lives at a different address, who would know how to contact you at any time:

Name: _____ Relationship: _____

Address: _____ Daytime Phone: _____

City: _____ State: _____ Zip Code: _____

2. Grievance In:

- | | | |
|-----------------------------------|-----------------------|-------|
| <input type="checkbox"/> Service | What is the service? | _____ |
| <input type="checkbox"/> Program | What is the program? | _____ |
| <input type="checkbox"/> Activity | What is the activity? | _____ |
| <input type="checkbox"/> Benefit | What is the benefit? | _____ |

3. **Reason for Grievance:** Describe the reason for the grievance. Include dates of each event. If necessary, attach an additional sheet(s) of paper.

4. **Date(s) of Alleged Action Related to Grievance:**

Beginning Date: _____

Ending Date: _____

5. Have you filed a similar complaint with any other federal or state agency?

Yes If yes, which agency: _____ Date filed: _____

No

I certify by checking this box I intend to file a grievance with the City of Sioux Falls. I declare and affirm that this information is, to the best of my knowledge, true and correct.

Signature of Complainant

Date