TITLE II
AMERICANS WITH DISABILITY ACT (ADA)
GRIEVANCE FORM

Please complete this form in blue ink or type. Sign and return this form to: Hinds County ADA Coordinator, George Nelson, 316 South President Street, Jackson, P.O. Box 686, Mississippi 39205-0686, gnelson@co.hinds.ms.us . This form can also be submitted via fax to (601) 968-6544.

1. **Full Name (Complainant):** _____
2. **Address:** _____
3. **City:** _____ **4. State:** _____
5. **Zip Code:** _____
6. **Home/Cell Phone: (_____)** _____ **7. Work Phone: (_____)** _____
8. **Person Discriminated Against (If other than the complainant):** _____
9. **Information of individual listed for No. 8:**

   Address: _____

   City: _____ **State:** _____

   Zip Code: _____

   Home/Cell Phone: (____) _____ **Work Phone: (____)** _____
10. **Name of the Hinds County Department, Service involved:** _____

    Address: _____

    City: _____ **State:** _____

    Zip Code: _____ **Work Phone: (_____)** _____
11. **Date alleged discrimination(s) occurred (Month/Date/Year):** _____
12. **Describe the acts of discrimination, provide name(s) where possible of individual(s) who discriminated against complainant:** _____

    _____

    _____

    _____

    _____

    _____

    _____

Over

13. **Have any complaints been filed with the Department of Justice, or any other Federal, State, or local civil rights agency or court related to this matter?**
    Yes_____ No_____
14. **If yes. Provide the following information:**
    1. **Name of the agency or court in which the complaint was filed or submitted:_____**
       _____
    2. **Name of the contact person with said agency or court: _____**
       _____
    3. **Address: _____**
    4. **City: _____** **5. State: _____**
    6. **Zip Code: _____**
    7. **Phone: (_____) _____** **8. Date Filed or Submitted: _____**

Additional Comments: _____

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Signature: _____ **Date: _____**