County of Riverside
ADA Complaint Resolution Procedure

This Complaint Resolution Procedure is established to meet the requirements of the Americans with Disabilities Act (ADA). It may be used by anyone who wishes to file a complaint alleging discrimination on the basis of disability in employment practices and policies or in the provision of services, activities, programs, or benefits by the County of Riverside.

The complaint should be in writing* and contain the complainant's contact information as well as information about the alleged discrimination, such as:

- location,
- date(s) of incident, and
- description of the specific problem.

The complaint should be submitted by the complainant and/or his/her designee as soon as possible but no later than 90 calendar days after the alleged violation to:

County of Riverside – Human Resources
Disability Access Coordinator
P.O. Box 1569
Riverside, CA 92502-1569

Main (951) 955-3510
TTY 711
FAX (951) 955-7954
Email ADA@rivco.org

Within 15 business days after receipt of the complaint, the Disability Access Coordinator will respond in writing, and, where appropriate, in a format accessible to the complainant. The response will explain the position of the County of Riverside and if appropriate, offer options for substantive resolution of the complaint. If the response by the Disability Access Coordinator does not satisfactorily resolve the issue, the complainant and/or his/her designee may appeal the decision of the Disability Access Coordinator within 15 business days after the receipt of the response to the Assistant CEO/Director of Human Resources for the County of Riverside or his/her designee.

If the ADA complaint is not resolved by the above internal process, the complainant will be referred to the appropriate State and/or Federal agency for assistance.

All written complaints received by the Disability Access Coordinator, will be maintained by the County of Riverside for at least three years.

*Alternative means of filing complaints will be made available for persons with disabilities upon request.

County of Riverside

ADA Complaint Resolution Form

Name:_____

Address:_____

City: _____ State: _____ Zip:_____ Phone:_____

Email Address: _____

County Department Name and Location:

_____

Relationship to Department:

☐ Employee (position) _____ Employee ID# _____
☐ Visitor
☐ Consumer/Client
☐ Applicant
☐ Resident
☐ Other (specify) _____

Description of Disability or Functional Limitations (optional):

_____
_____
_____

Date(s) of Incident: _____

Statement of Complaint:

_____
_____
_____
_____
_____

What Action are You Requesting? _____
_____
_____
_____

_____ _____
Signature Date