# DESCHUTES COUNTY, OREGON

# GRIEVANCE PROCEDURE UNDER THE AMERICANS WITH DISABILITIES ACT

This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act of 1990. It may be used by anyone who wishes to file a complaint alleging discrimination on the basis of disability in the provision of services, activities, programs, or benefits by the County. The County's Personnel Policies govern employment-related complaints of disability discrimination.

The complaint should be filed in writing using the ADA Complaint form in Appendix A. Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint will be made available for persons with disabilities upon request.

The complaint should be submitted by the grievant and/or their designee as soon as possible but no later than 60 calendar days after the alleged violation to:

**ADA Coordinator**
**Administrative Services Department**
**1300 NW Wall Street**
**Bend, Oregon 97703**
**(541) 388-6584 or (541) 617-4747**

**Or emailed to: accessibility@deschutes.org**

Within 15 calendar days after receipt of the complaint, the **ADA Coordinator** or their designee will contact or meet with the complainant to discuss the complaint and the possible resolutions. Within 15 calendar days of the contact, the **ADA Coordinator** or their designee will respond in writing, and where appropriate, in format accessible to the complainant, such as large print, Braille, or audio tape. The response will explain the position of the ***County*** and offer options for substantive resolution of the complaint.

**Disputes:** If the response by the **ADA Coordinator** or their designee does not satisfactorily resolve the issue, the complainant and/or their designee may appeal the ADA Coordinator's response within 15 calendar days after receipt of the response to the **County Administrator** or their designee.

Within 15 calendar days after receipt of the appeal, the **County Administrator** or their designee will meet with the complainant to discuss the complaint and possible

resolutions. Within 15 calendar days after the meeting, the **County Administrator** or their designee will respond in writing, and, where appropriate, in a format accessible to the complainant, with a final resolution of the complaint.

All written complaints received by the **ADA Coordinator** or their designee, appeals to the **County Administrator** or their designee, and responses from these two offices will be retained by the County for at least three years.

Deschutes County prefers that complaints and disputes be filed directly with the County such to expedite a response. However, complaints and disputes can also be filed with:

**Office for Civil Rights**
**U.S. Dept. of Health and Human Services**
**2201 Sixth Avenue- Mail Stop RX-11**
**Seattle, Washington 98121-1831**
**1-800-368-1019**
**TDD: 1-800-537-7697**

If you are a member of the Oregon Health Plan you have the additional option of:

**Contacting your managed care plan or Oregon Health Plan Ombudperson Office 1-800-442-5238**

Appendix A

# DESCHUTES COUNTY
# ADA COMPLAINT FORM

## *CONSOLIDATED CIVIL RIGHTS COMPLAINT FORM*

| Your Name | Phone | Alternative Phone |
|---|---|---|
| Street Address | City, State | Zip Code |

| Person(s) discriminated against (if different than the preparer of this form) | | |
|---|---|---|
| Street Address | City, State | Zip Code |

| I believe that I (or the person(s) listed above) has been discriminated against on the basis of: | | | | | |
|---|---|---|---|---|---|
| | Race (Title VI) | | Color (Title VI) | | National Origin (Limited English Proficiency) (Title VI) |
| | Disability (ADA) | | | | |

| Please describe the alleged discrimination incident. Provide the names and titles of all employees involved, if available. Explain what happened and whom you believe was responsible. Please use the back of this form if more space is required. **NOTE: This form consolidates information required by multiple federal civil rights programs. Information will be shared based on the type of discrimination identified above. Title VI of the Civil Rights Act covers Race, Color, and National Origin complaints ONLY. Americans with Disabilities Act covers Disability complaints.** | |
|---|---|
| Date of Incident: | |
| | |

| Have you filed this complaint with any other federal, state, or local agency? | | Yes | | No |
| --- | --- | --- | --- | --- |
| If yes, Agency Name | | | | |
| Agency Address | | | | |
| Agency Contact Name (if available) | | | | |

I affirm that I have read the above charge and that it is true to the best of my knowledge, information and belief.

Signature: ________________________ Date: _____________

Print Name: ______________________

The form may be hand delivered, mailed, or emailed:

Hand deliver to:

ADA Coordinator
Administrative Services Department
Deschutes County
1300 NW Wall Street
Bend, OR 97703

Mail to:

ADA Coordinator
Administrative Services Department
Deschutes County
PO Box 6005
Bend, OR 97703

Email to: accessibility@deschutes.org

*If this form is needed in another language or format, please call 541-388-6570.*
*Si se necesita esta información en un idioma o formato diferente, por favor llame a 541-388-6570.*