Pennyrile Allied Community Services
ADA/Section 504 Program Complaint

Information and Instructions:
ADA/Section 504 of the Rehabilitation Act of 1973 forbids denying qualified individuals with disabilities to participate in any programs receiving federal financial assistance. The complain process is designed for members of the public to resolve conflicts with the Pennyrile Allied Community Services involving allegations of discrimination in access to PACS programs, services, and activities for persons with disabilities pursuant to the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

SECTION 1: COMPLAINANT INFORMATION:

NAME: (first, mi, last)	**MAILING ADDRESS:**	
CITY STATE ZIP		
	PREFERRED METHOD of Contact	
TYPE OF DISABILITY:	**□Home Phone:**	
□ Speech □ Mobility □ Hearing	**□ Email Address:**	
□ Mental/Emotional □ Visual □ Other	**□ Cell:**	
	□ Other:	

ATTORNEY REPRESENTATION FOR THIS COMPLAINT: (if any)

Name: (first, mi, last)		**Firm Name:**	
Street Address:		**Phone Number:**	
City, State, Zip:		**Email Address:**	

SECTION 2: INCIDENT DETAILS:
Select each of the following that is applicable to the denied access of complainant:

□Public Rights-of-Way □ Program □ Service □ Activity □ Other

Provide a detailed explanation of the denied accessibility incident. Provide dates, location, and time. If there are witnesses, provide names, addresses, and phone numbers for each witness.

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SECTION 2: INCIDENT DETAILS (cont.)

SECTION 3: GOVERNMENT, ORGANIZATION, OR INSTITUTION BELIEVED TO HAVE DISCRIMINATED:
Company Name:
Street Address:
Phone: **Person Compliant Spoke with & Title:**
PROPOSED RESOLUTION OR ACCOMODATION (what remedy is being requested? Be specific)

Have you filed this complaint with any other federal, state, or local agency or with any federal or state court? □ YES □ NO DATE:
AGENCY NAME:

PERSON/TITLE COMPLAINT DIRECTED TO:

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SECTION 4: SIGNATURE AUTHORIZATION AND ADDITIONAL INSTRUCTIONS

By giving my signature below, I acknowledge that the information provided on this form is true and accurate to the best of my knowledge, and I accept that I may be contacted by a PACS Office for Civil Rights and Small Business Development official regarding this complaint.

Signature: _____ **Date:**

Return this form to:

Pennyrile Allied Community Services
Att: Kristine George, Transportation Director
PO Box 549, Hopkinsville, KY 42241

PACS does not discriminate on the basis of disability in admission of its programs, services, or activities; in access to them, in treatment of individuals with disabilities, or in any aspect of their operations. PACS also does not discriminate on the basis of disability in its hiring or employment practices.

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. Questions, complaints, or requests for additional information regarding the ADA and Section 504 may be addressed to:

Pennyrile Allied Community Services
Attn: Kristine George
PO Box 549, Hopkinsville, KY 42241

This notice is available in large print, on audio tape, and in Braille upon request to the ADA Coordinator.