COMMUNITY DEVELOPMENT COMMISSION
HOUSING AUTHORITY
OF THE COUNTY OF LOS ANGELES

700 West Main Street ▪ Alhambra ▪ CA ▪ 91801
Phone: (626) 262-4511 | TTY (626) 943-3898
Email: Claims@lacdc.org

ADA COMPLAINT FORM INSTRUCTIONS & GREVIANCE PROCEDURES

CDC GRIEVANCE PROCEDURE: This Grievance 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 the provision of services, activities, programs, or benefits provided by the Community Development Commission of the County of Los Angeles (Commission) and the Housing Authority of the County of Los Angeles (HACoLA).

Complaints should be presented in writing and contain information about the alleged discrimination. Information shall include the name, address, phone number of complainant, location of occurrence, date, and description of the problem. 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 his/her designee as soon as possible but no later 60 calendar days after the allege violation to:

Community Development Commission / Housing Authority
of the County of Los Angeles
Attn: JULLIETTE LARIN, ADA COORDINATOR
700 W. Main Street, Alhambra, CA 91801
Phone: (626) 586-1695 | TTD: (855) 892-6095 | Email: Claims@lacdc.org

The Commission/HACoLA shall:

- **Within 15 calendar days** after receipt of the complaint, the ADA coordinator (or designee) shall communicate with and or meet with the complainant to discuss the complaint and possible resolutions.
- **Within 30 calendar days or within a reasonable time frame** after the meeting/communication the ADA coordinator (or designee) shall respond in writing, and, where appropriate, respond in a format accessible to the complainant, such as large print, Braille, or audio tape. The response will explain the position of Commission/HACoLA and offer options for substantive resolution of the complaint.

Appeal Process: If the response by the ADA coordinator (or designee) does not satisfactorily resolve the issue, the complainant (or their designee) may appeal the decision of the ADA coordinator within 15 calendar days to the Commission/HACoLA's Human Resources Director (or designee).

Within 30 calendar days or within a reasonable time frame after receipt of the appeal, the Human Resources Director (or designee) shall communicate with and or meet with the complainant to discuss the complaint and possible resolutions. **Within 30 Calendar days after the meeting** the Human Resources Director (or designee) shall respond in writing, and, where appropriate, respond in a format accessible to the complainant, with a final resolution of the complaint.

Other Remedies: The right of a person to a prompt and equitable resolution of the complaint filed will not be impaired by the person's pursuit of other remedies such as the filing of an ADA complaint with the responsible federal department or agency. Use of this grievance procedure is not required prior to the pursuit of other remedies. These rules are intended to protect the rights of interested persons, meet the appropriate due process standards and ensure the Commission/HACoLA complies with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

Records Retention: All written complaints and communications related to ADA shall be maintained by the Commission/HACoLA for a minimum of three years beginning from the date a matter is deemed closed.

THIS MATERIAL IS AVAILABLE IN ALTERNATIVE FORMATS UPON REQUEST

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COMPLAINT FORM - AMERICANS WITH DISABILITIES ACT (ADA)

This form is for submitting complaints alleging the Community Development Commission of the County of Los Angeles (CDC) / Housing Authority of the County of Los Angeles (HACoLA) have not complied with the Americans with Disabilities Act (ADA) of 1990. All complaints will be investigated.

Date of Incident: _____ Violation by (Check one or both): ☐ HACoLA ☐ CDC

Location of Occurrence (Complete Address): _____

Complainant's Name: _____ Authorized Representative: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Mobile: _____ Email: _____

Alleged Violation(s): Please describe the alleged denial or exclusion of services, activities, programs or benefits and your reason(s) for concluding that the conduct was discriminatory. Please include the name(s) of witnesses, if any, and attached supporting data if available.

Requested Action: What resolution do wish the CDC/HACoLA take to correct the alleged discrimination.

Are the circumstatnce of your complaint continuing? ☐ Yes ☐ No
Have you filed a claim regarding this complaint with a federal, state, or local governement agency? ☐ Yes ☐ No
Have you hired an attorney with respect to the allegations in the complaint? ☐ Yes ☐ No
Have you instituted a legal suit or court action regarding this complaint? ☐ Yes ☐ No

SIGNATURE REQUIRED: *I certify under penalty of perjury under the laws of the State of California that the information entered by me on this document is true and correct.*

Complainant's Printed Name	Complainant's Signature	Date
Authorized Representative Printed Name	Authorized Representative Signature	Date

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Office Use Only: Form completed by ADA Coordinator/Representative: Print Name: _____ Signature: _____ Date: _____