State of Illinois
Department of Human Services

AMERICANS WITH DISABILITIES ACT/ SECTION 504 GRIEVANCE REQUEST

Name of Complainant: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ (Voice or text telephone)

Please Indicate Facility/Local Office

Name: _____

Address: _____

Telephone: _____

Staff Name and Job Title: _____

Program/Service Name: _____

Please include the alleged facts and nature of the alleged denial or discrimination (include name(s) and phone number(s) of witness(es). For additional space, attach an additional page):

Please specify date of the alleged denial or discrimination: _____

Relief requested:

_____ _____

Complainant's Signature Date

The American's with Disabilities Act coordinator will provide a written response to the Complainant within 45 days after the receipt of the Grievance Request. This form is also available in braille, large print, audiotape or computer disk upon request.

Send completed form to:

DHS-ADA Coordinator
Bureau of Accessibility and Job Accommodation
401 South Clinton, 3rd Floor
Chicago, IL 60607

Print Form Reset Form