



**DEPARTMENT OF PUBLIC HEALTH (DPH)
AMERICANS WITH DISABILITIES ACT (ADA)
COMPLAINT FORM**



This form is for a DPH informal complaint procedure, designed to quickly resolve complaints regarding violations of the Americans with Disabilities Act.

You may file a complaint if you feel that you have been discriminated against due to your disability or are not satisfied with the service you received related accommodating your disability.

Some disabilities may include, but are not limited to problems with walking, sitting, standing, reading, learning, understanding, speaking, or hearing.

Instructions

1. Complaint must be in writing and should contain the name, address, and telephone number of complainant along with a brief description of the alleged violation(s).
2. Please include the corrective action being requested to resolve the alleged violation(s).
3. All complaint forms should be signed.
4. You may mail or email your complaint(s) to DPH ADA Compliance Coordinator or Chief Executive Office (CEO), Disability Civil Rights Section at:

ADA Compliance Coordinator
Department of Public Health
5555 Ferguson Drive, Suite 3033
Commerce, CA 90022
Telephone: 1 (844) 914-1006
Email: DPH-ADA@ph.lacounty.gov

California Relay Service (Free)
Dial 7-1-1 to be connected

Chief Executive Office
Disability Civil Rights Section
500 West Temple Street, Room 754
Los Angeles, California 90012
Telephone: (213) 202-6944
TTY: (855) 872-0443
Email: Adavis@ceo.lacounty.gov

5. You may request an informal meeting with the DPH ADA Compliance Coordinator to answer any questions.
6. DPH will acknowledge receipt of your complaint in writing within five (5) workdays from the date the complaint was filed.

Please Note:

- Using this informal complaint procedure is not a requirement under federal regulations nor does it prevent you from filing a complaint with the appropriate federal enforcement agency.
- Any retaliation, coercion, intimidation, threat, interference, or harassment for filing of a complaint is prohibited and should be reported immediately to the DPH ADA Compliance Coordinator: (844) 914-1006 or to the County's CEO, Disability Civil Rights Section: 202-6944.

This form is available in alternate format from the Departmental ADA Coordinator upon request.



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Person completing form (**check one**): Complainant Authorized Representative

Name: _____

Address: _____

Telephone No.: (_____) _____

Email: _____

ALLEGED VIOLATIONS

Describe how the County of Los Angeles has not complied with the ADA. Provide sufficient detail to make your complaint clear (attach additional pages if necessary).

Date of Occurrence: _____

REQUESTED ACTION

What actions do you request the County take to correct the alleged ADA non-compliance or discrimination?

Signature: _____ Date: _____