



Complaint Intake Form  
Complaint No. \_\_\_\_\_

**ADA Complaint Intake Form**

Name \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

City, State, Zip code \_\_\_\_\_

Name of person filling out this form if other than the complainant:

\_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type of Complaint: (Check appropriate category): ADA \_\_\_\_ TITLE VI DISCRIMINATION \_\_\_\_

Date/Time/Location of Incident: \_\_\_\_\_

Name or description of individual the complaint is against: \_\_\_\_\_

Brief Description of Complaint: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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Use an additional page if necessary

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