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**PASSAIC COUNTY GRIEVANCE PROCEDURE UNDER THE AMERICANS WITH DISABILITIES ACT**

This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act of 1990 (“ADA”). It may be used by anyone who wishes to file a complaint alleging discrimination on the basis of disability in the provision of services, activities, programs, or benefits by the County of Passaic. The County’s Personnel Policy governs employment-related complaints of disability discrimination.

The complaint should be in writing and contain information about the alleged discrimination such as name, address, phone number of complainant and location, 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 than 60 calendar days after the alleged violation to:

Kenneth Hirmann ADA Coordinator

401 Grand Street Room 123

Paterson NJ 07505

973-881-4531

kenh@passaiccountynj.org

Within 15 calendar days after receipt of the complaint, Kenneth Hirmann or his designee will meet with the complainant to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, Mr. Hirmann or his designee will respond in writing, and where appropriate, in a format accessible to the complainant, such as large print, Braille, or audio tape. The response will explain the position of the County of Passaic and offer options for substantive resolution of the complaint.

If the response by Mr. Hirmann or His designee does not satisfactorily resolve the issue, the complainant and/or their designee may appeal the decision within 15 calendar days after receipt of the response to the County Administrator or his designee. Within 15 calendar days after receipt of the appeal, the County Administrator or his designee will meet with the complainant to discuss the complaint and possible resolutions. Within 15 calendar days after the meeting, the County Administrator or his designee will respond in writing, and, where appropriate, in a format accessible to the complainant, with a final resolution of the complaint.

**Americans with Disabilities Act Discrimination Complaint Form**

Instructions: Please fill out this form completely, in black ink or type. Sign and return.

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| Complainant: |
| Address: |
| City, State and Zip Code: |
| Cell Phone: Business Telephone Number: |
| Person Discriminated Against (if other than the Complainant): |
| Address: |
| City, State, and Zip Code: |
| Cell Phone: Business Telephone Number: |
| Name of Entity that Discriminated Against Claimant/Other |
| Address: |
| City, State and Zip Code: |
| Telephone Number: |
| When did the discrimination occur (provide date):  Describe the acts of discrimination. If possible, provide specific names of the individuals involved. |
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Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, or institution?

Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

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| If yes, what is the status of the grievance: |
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**Signature: Date:**