



## ADA/SECTION 504 PROGRAM COMPLAINT

ADA/Section 504 of the Rehabilitation Act of 1973 forbids denying qualified individuals with disabilities to participate in any programs receiving federal financial assistance. The complaint process is designed for members of the public to resolve conflicts with LKLP involving allegations of discrimination in access to LKLP programs, services, and activities for persons with disabilities pursuant to the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

### SECTION 1: COMPLAINANT INFORMATION

NAME <i>(first, mi, last)</i>			MAILING ADDRESS	
CITY	STATE	ZIP	PREFERRED METHOD OF CONTACT	
TYPE OF DISABILITY			<input type="checkbox"/> Home phone _____	
			<input type="checkbox"/> Email Address _____	
<input type="checkbox"/> Speech	<input type="checkbox"/> Mobility	<input type="checkbox"/> Hearing	<input type="checkbox"/> Alt/Cell _____	
<input type="checkbox"/> Mental/Emotional	<input type="checkbox"/> Visual	<input type="checkbox"/> Other		

### ATTORNEY REPRESENTATION FOR THIS COMPLAINT *(if any)*

NAME <i>(first, mi, last)</i>		FIRM NAME	
ADDRESS	CITY	STATE	ZIP
PHONE	EMAIL		

### SECTION 2: INCIDENT DETAILS

Select each of the following that is applicable to the denied access of complainant:

- Public Rights-of-Way     Program     Service     Activity

Provide a detailed explanation of the denied accessibility incident. **Provide dates, location, and time.** If there are witnesses, provide names, addresses, and phone numbers for each witness.



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**SECTION 2: INCIDENT DETAILS** *(cont.)*

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**SECTION 3: GOVERNMENT, ORGANIZATION, OR INSTITUTION BELIEVED TO HAVE DISCRIMINATED**

<b>COMPANY NAME</b>		<b>STREET ADDRESS</b>	
<b>MAILING ADDRESS</b> <i>(if different from street address)</i>		<b>CITY</b>	<b>STATE</b>   <b>ZIP</b>
<b>PHONE</b>	<b>PERSON COMPLAINANT SPOKE WITH</b>	<b>TITLE</b> <i>(if known)</i>	

**PROPOSED RESOLUTION OR ACCOMMODATION** *(What remedy is being requested?)(Be specific.)*

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Have you filed this complaint with any other federal, state, or local agency or with any federal or state court?

Yes     No

<b>AGENCY NAME</b>	<b>DATE</b>
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<b>PERSON/TITLE COMPLAINT DIRECTED TO</b>
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### SECTION 4: SIGNATURE AUTHORIZATION & ADDITIONAL INSTRUCTIONS

By providing my signature below, I acknowledge that the information provided on this form is true and accurate to the best of my knowledge, and I accept that I may be contacted by a representative of LKLP in regards to this complaint.

**SIGNATURE**

**DATE**

Return this form to:

LKLP CAC, Inc.  
ADA/Section 504 Coordinator  
398 Roy Campbell Drive  
Hazard, KY 41701

LKLP does not discriminate on the basis of disability in admission of its programs, services, or activities; in access to them, in treatment of individuals with disabilities, or in any aspect of their operations. LKLP also does not discriminate on the basis of disability in its hiring or employment practices.

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. Questions, complaints, or requests for additional information regarding the ADA and Section 504 may be addressed to:

LKLP CAC, Inc.  
ADA/Section 504 Coordinator  
398 Roy Campbell Drive  
Hazard, KY 41701

This notice is available in large print, on audio tape, and in Braille upon request to the ADA Coordinator.