



## **Dougherty 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 **Dougherty County**. 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:

**Michael McCoy**  
**Assistant County Administrator/ADA Coordinator**  
**P. O. Box 1827**  
**Albany, Georgia 31702**  
**229-431-2121**  
**mmccoy@dougherty.ga.us**

Within 15 calendar days after receipt of the complaint, The **ADA Coordinator** will meet with the complainant to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, the **ADA Coordinator** will respond in writing, and where appropriate, in a format accessible to the complainant. The response will explain the position of the **County** and offer options for substantive resolution of the complaint. It shall be the duty of the **ADA Coordinator** to render timely decisions and to utilize the best efforts to resolve any disputes presented by the grievance regarding matters under the Americans with Disabilities Act and 28 C.F.R. 35.107 (B), and as these may be amended from time to time.

If the response by the **ADA Coordinator** does not satisfactorily resolve the issue, the complainant and/or his/her designee may appeal the decision within 15 calendar days after receipt of the response to the **County Administrator**.

Within 15 calendar days after receipt of the appeal, the **County Administrator** will meet with the complainant to discuss the complaint and possible resolutions. Within 15 calendar days after the meeting, the **County Administrator** will respond in writing, and, where appropriate, in a format accessible to the complainant, with a final resolution of the complaint.

All written complaints received by the **ADA Coordinator** designee, appeals to the **County Administrator** and responses from these two offices will be retained by the **County** for at least three years.

**DOUGHERTY COUNTY BOARD OF COMMISSIONERS**

ADA Coordinator  
PO Box 1827  
222 Pine Avenue Ste 540  
Albany, Georgia 31702  
(229) 431-2121  
(229) 438-3967 (fax)

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**Title II of the Americans with Disabilities Act  
Section 504 of the Rehabilitation Act of 1973**

**Grievance Complaint Form**

Instructions: Please fill out this form completely, sign and return to:

Dougherty County ADA Coordinator  
Dougherty County Board of Commissioners  
PO Box 1827  
222 Pine Avenue Ste 540  
Albany, Georgia 31702  
(229) 431-2121  
(229) 438-3967 (fax)

Complainant:

\_\_\_\_\_

Address:

\_\_\_\_\_

City, State, Zip Code:

\_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Person Discriminated Against (if other than complainant)

\_\_\_\_\_

Address:

\_\_\_\_\_

City, State, Zip Code:

\_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

County government department, facility, or program which you believe has discriminated:

Name:

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Address:

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City, State, Zip Code:

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Telephone: \_\_\_\_\_

When did the discrimination occur? Date: \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated:

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Have efforts been made to resolve this complaint through the County Department?

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

If yes, what is the status of the grievance?

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

**Grievance Complaint Form  
Review and Comment**

**ADA Coordinator**

Date received: \_\_\_\_\_ By: \_\_\_\_\_

Date interview conducted: \_\_\_\_\_

Investigative process and findings: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Action Taken:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADA Coordinator Signature: \_\_\_\_\_

**SECOND LEVEL – COUNTY ADMINISTRATOR**

Date received: \_\_\_\_\_

Date hearing conducted: \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Action Taken and Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attach any supporting documentation.  
Copy to: Department File