

PARTNERS IN CARE MARYLAND, INC. ADA-RELATED COMPLAINT FORM

Partners In Care Maryland, Inc. is committed to providing safe and accessible transportation services. Any person who believes he or she has been discriminated against on the basis of disability by Partners In Care Maryland, Inc. may file a complaint by completing and submitting this form (by) mail to its offices at 8151-C Ritchie Highway, Pasadena, Maryland, 21122. You may also file your complaint by phone at 410-544-4800, Ext. 201 or by email at ssmith@partnersincare.org. Please make sure to provide us with your contact information in order to receive a response.

SECTION I: CONTACT INFORMATION

Name of Individual discriminated against:

Rider/Client ID (if applicable):

Street Address:

City, State, Zip Code:

Telephone (Work, Cell, Other):

Email:

Accessible Format Requirements:

Large Print TDD/Relay Audio Recording Other

If you are completing this form on behalf of the individual named above, please complete the following:

- a. Please indicate the relationship you have with the person who is filing the complaint.
- b. Explain why you are completing this form for the person filing the complaint.
- c. Please confirm you have obtained the permission to complete this form from the person filing the complaint. Yes No
- d. Your contact information:
Name:
Address:
Telephone (Work, Cell, Other)
Email:

Accessible Format Requirements:

Large Print TDD/Relay Audio Recording Other

SECTION II: COMPLAINT DETAILS

Date of Occurrence:

Explain as clearly as possible what happened and why you believe you were discriminated against. Include the location and describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please use additional sheets. You may also attach any written materials or other information that you think is relevant to your complaint.

Mobility Aid Used (if any):

Have efforts been made to resolve this complaint: No Yes – if yes, what is the status?

Have you previously filed an ADA complaint with Partners In Care Maryland, Inc.? No Yes
If yes, please indicate date of previous complaint.

Have you filed this complaint with any other local, State or Federal agency, or with any Federal or State court? No Yes – If yes, please indicate which agency(ies) or court (s).

SECTION III: FOLLOW-UP

What corrective actions do you believe would address your complaint?

Would you like a response following our investigation of this complaint? Yes No

May we contact you if we need more details or information? Yes No

What is the best way to reach you? (Choose one) [Phone, Email, etc.]

If a phone call is preferred, what is the best day and time to reach you?

SIGNATURE AND DATE REQUIRED BELOW

Signature: _____

Date: _____