



AMERICANS WITH DISABILITIES ACT (ADA) GRIEVANCE FORM

Please use this form to file a grievance based upon disability in the provision of services, activities, programs, or benefits. If you need additional assistance, we would be happy to provide it.

Your First Name: _____ Your Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No: _____ Email: _____

Preferred Contact Method (Circle One) Email Phone US Mail

Complaint Type:

- Program Access
- Physical Access
- Digital accessibility (website, online forms, online services, etc.)
- Other: _____

Complaint Description (Please use back of sheet or attached additional information if needed):

Location of Physical Access grievance/barrier, if applicable. Please be specific:

Street Address/Nearest Cross-Street: _____

Direction of Travel/Side of Street: _____

Signature _____

Date _____

Email: adacoordinator@ci.benicia.ca.us

Phone: 707-746-4200 (CRS dial 711)

Mail or delivery: ADA Coordinator for City of Benicia, 250 East L Street, Benicia, CA 94510