



# City of Sharonville

## The Americans with Disabilities Act Grievance Procedure

This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act ("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 City of Sharonville. The City of Sharonville's Policy & Procedure Manual 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 audio recording of the complaint will be made available for persons with disabilities upon request.

The complaint should be submitted by the grievant and/or their designee as soon as possible but no later than 60 calendar days after the alleged violation to: **Rachel Combs ADA Coordinator, Human Resource Department, 10900 Reading Road, Sharonville, OH 45241.**

Within 15 calendar days after receipt of the complaint, Rachel Combs or her designee will arrange to meet with the complainant to discuss the complaint and the possible resolutions. An information investigation, as may be appropriate, shall follow the filing of a complaint. The ADA Coordinator or appropriate designee shall conduct the informal investigation within 30 days after the initial receipt of the grievance.

Within 15 calendar days of the meeting or the conclusion of the informal investigation, whichever occurs later, Rachel Combs or her designee will respond in writing, and where appropriate, in a format accessible to the complainant, such as large print, Braille, or audio recording. The response will explain the position of City of Sharonville, determine the validity of the grievance, if any, and offer options for substantive resolution of the complaint.

If the response by Rachel Combs or her 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 Safety/Service Director or his designee.

Within 15 calendar days after receipt of the appeal, the Safety/Service Director or his designee will arrange to meet with the complainant to discuss the complaint and possible resolutions.

Within 15 calendar days after the meeting, the Safety/Service Director or his designee 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 Rachel Combs or her designee, appeals to the Safety/Service Director or his designee, and responses from these two offices will be retained by City of Sharonville in the Administration Department.

The right of a person to a prompt and equitable resolution of the complaint filed under this Grievance Procedure shall not be impaired by the person's pursuit of other remedies, such as the filing of an ADA complaint with the responsible federal and/or state department or agency. Use of this grievance procedure is not a prerequisite to the pursuit of other remedies.



**Rachel Combs**

AMERICANS WITH DISABILITIES ACT (ADA) COORDINATOR

10900 Reading Road

Sharonville, Ohio 45241

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(513) 563-1144

FAX: (513) 563-0617

**Title II of the Americans with Disabilities Act  
GRIEVANCE FORM**

**1. COMPLAINANT INFORMATION:**

Name of Complainant:

\_\_\_\_\_

Last

MI

First

Address:

\_\_\_\_\_

\_\_\_\_\_

City

State

Zip

Telephone  
Number:

E-mail address:

\_\_\_\_\_

Preferred Method(s) of Communication: (Check all that apply)

Voice Telephone

TTY

E-mail

US Mail

Other: \_\_\_\_\_



2. **DESCRIBE YOUR COMPLAINT OF DISCRIMINATION BASED UPON DISABILITY:**  
Be specific and give date(s), time(s) and location(s). Use the reverse side of this sheet or attached pages, if needed.
  
3. **PERSONS NAMED IN YOUR COMPLAINT:** List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Department if possible.
  
4. **WITNESSES TO YOUR COMPLAINT:** List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Department, if possible.
  
5. **EVIDENCE AND DOCUMENTATION:** List and provide any physical evidence, written or recorded documents, or any other information that directly supports your specific claim of discrimination.
  
6. **CASE REMEDY AND/OR RESOLUTION:** What remedies or resolutions are you seeking?



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**CERTIFICATION**

**I hereby certify that the information and statements provided above are true.**

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

If Complainant is not the individual completing this form, please provide:

Representative's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

For more information or assistance in completing this form, please contact Rachel Combs – ADA Coordinator via phone 513-563-1144, (fax) 513-563-0617 or (email) [rcombs@cityofsharonville.org](mailto:rcombs@cityofsharonville.org)