CITY OF GREAT FALLS

ADA SUGGESTION/COMMENT/COMPLAINT FORM

SECTION I: TYPE OF COMMENT (Choose One)
Compliment _☐_ Suggestion _☐_ Comment _☐_ Complaint _☐_
SECTION II: CONTACT INFORMATION
Name:
Street Address:
City, State, Zip Code:
Phone: Email:
Accessible Format Requirements: Large Print _☐_ Relay _☐_ Audio Recording _☐_ Other _☐_
SECTION III: COMMENT DETAILS (Please provide sufficient details. Include: description of alleged discriminatory action, names, dates, places, actions/events, witnesses, etc.).
[☐] Check Here if additional pages are attached.
Please Specify What Corrective Action You Are Seeking
[☐] Check Here if additional pages are attached.
SECTION IV: FOLLOW UP
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 _☐_ Mail _☐_
If a phone call is preferred, what is the best day and time to reach you?

SECTION V: DESIRED RESPONSE

Choose One: Email Response ☐ Telephone Response ☐ Response by Mail ☐

_____ _____

Signature of Person Making Complaint Date

Printed Name: _____

Complaints should be addressed to: City of Great Falls, P.O. Box 5021, Great Falls, MT 59403

☐ PUBLIC FACILITIES – City of Great Falls, ATTN: PW ADA COORDINATOR, P.O. Box 5021, Great Falls, MT 59403; or, 1025 25th Avenue NE, Great Falls, MT 59404

☐ CITY SERVICES – City of Great Falls, ATTN: ADA COMPLAINT COORDINATOR, CITY CLERK, P.O. Box 5021, Great Falls, MT 59403; or, 2 Park Drive South, Room 204, Great Falls, MT 59401.

☐ CITY EMPLOYEES – City of Great Falls, ATTN: HUMAN RESOURCES DIRECTOR, P.O. Box 5021, Great Falls, MT 59403; or, 2 Park Drive South, Room 202, Great Falls, MT 59401

Telecommunications Device for the Deaf – Dial 711 or 1-800-253-4091 to use the Montana Relay Service.

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FOR CITY USE ONLY

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Signature of Person Receiving Complaint Date _____

Title: _____