Print Form

RI Governor's Commission on Disabilities

RI GCD Form D 2. Disability Rights State or Local Government Discrimination Complaint and Mediation Request

If you were subject to discriminatory action relating to services provided by an agency of the State of Rhode Island, a municipality (city or town), a public school district, fire /water district, other local government agency, or a contractor of a government agency, the Commission may be able to assist. The Commission is not authorized to receive complaints against United States Government Agencies. These complaints should be filed with the US Department of Justice, Civil Rights Division, P. O. Box 66118, Washington, DC 20035-6738; phone number 1-800-514-0301 (voice) or 1-800-514-0383 (tty).

The Commission does not have the authority to order a government agency to stop the discrimination, unless it is the result of a facility not being physically accessible.

If you complete this form the Commission will contact the agency, attempt to set up meetings between you, the agency and mediators, to allow all the parties to jointly develop a solution to the problem(s).

You should also file a government services discrimination charge with the United States Department of Justice/ Civil Rights Division / ADA Office; and / or the RI Commission for Human Rights.

If you need a reasonable accommodation in order to complete this form, please notify the Commission and assistance will be provided to you.

Complainant's Name			
Day Time Phone #		☑ Check if TTY	☐
Home Address			
City, State & Zip Code			
Email address			
☑ check type of agency:	State agency/department	☐	Public school district ☐
	Municipal government agency	☐	Fire /Water District ☐
	Public Housing Authority	☐	Government contractor ☐
	Non -profit government grantee/contractor		☐

Information of the government agency you are filing against:

Agency Director's Name & Title	
Agency	
Address	
City, State & Zip Code	

If you wish to file a charge against a specific person who discriminated against you, provide their full name, address and phone number

That Person's Name & Title			
That Person's Address			
City, State & Zip Code			
That Person's Phone #		Email address	

Please specify the date(s) the alleged discrimination took place					
Only once, on		More than once or ongoing between:		and	

Because of my disability:	☑ Check one or more
I was denied the opportunity to participate in or benefit from the aid, benefit, or service	☐
I was provided an aid, benefit, or service that is not equal to that afforded others	☐
I was provided an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others who were not disabled	☐
I was provided a different or separate aids, benefits, or services than is provided to others who were not disabled	☐
I was denied the opportunity to participate as a member of planning or advisory boards	☐
I was unable to participate or use the aid, benefit, or service because of the site or location of that aid, benefit, or service, was not accessible	☐
I was unable to participate or use the aid, benefit, or service because the agency refused to make reasonable modifications in of its policies, practices, or procedures	☐
I was unable to participate or use the aid, benefit, or service because the agency imposed or applied eligibility criteria that screen out or tend to screen out individuals with a disability	☐
I was required to pay a surcharge to cover the costs of measures, such as the provision of auxiliary aids or program accessibility	☐
The agency did not maintain in operable working condition those features of facilities and equipment that are required to be readily accessible to and usable by persons with disabilities	☐
I was denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services	☐
I am not disabled but was denied equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom I have a relationship or association	☐

Please explain below what action was taken against you that you believe was discriminatory. Were other persons treated differently than you? What harm, if any, was caused to you as a result of that action? Please include all relevant names and dates. If you filed a charge against a specific person, you must explain the discriminatory actions that this person took.
If you have any documents concerning the situation, please attach copies to your statement.

(attach additional sheets if necessary)

☑ Check if the agency knew you had a disability prior to the alleged discrimination ☐

Describe how the agency knew about your disability: did you complete a self- identification of disability form, request an accommodation, verbally inform a supervisor, is your disability visible.

☑ Check if you sought any assistance about the action you think was discriminatory from any other government agency, civil rights enforcement agency, or from any other source ☐

Name of the agency			
Mailing address			
City, State & Zip Code			
Office Phone #		Email address	
Describe the results of that assistance			

☑ Check if you sought any assistance of a lawyer ☐

Name of the law firm			
Mailing address			
City, State & Zip Code			
Name of the lawyer			
Office Phone #		Email address	

☑ Check if you wish to be represented by that lawyer during mediation ☐

I understand that the Governor's Commission on Disabilities offers to attempt to quickly resolve disability discrimination complaints through mediation. **The Commission will send a copy of this form to the business or agency that I have filed against and urge them to mediate the complaint.** The Governor's Commission on Disabilities is not empowered to compel that a business or agency participate in mediation, except a state government agency.

I further understand that I may pursue my complaint before the appropriate state and/or federal civil rights enforcement agency and the federal and state courts, while the Commission attempts to resolve my complaint through mediation. If the mediation is completely successful, the business or agency I have filed against will want any complaints filed with those state or federal civil rights enforcement agencies and/or the state or federal courts withdrawn as part of its settlement of this complaint.

I agree to participate in the Commission's effort to mediate my complaint.

Date Signed		**Complainant's Signature**	

Emailed this form to disabilities@gcd.ri.gov if signed with an electronic signature or mail to the:

RI Governor's Commission on Disabilities
John O. Pastore Center, 41 Cherry Dale Court
Cranston, RI 02920-3049

and keep a copy of the completed form for you records