



## NOTICE UNDER THE AMERICANS WITH DISABILITIES ACT

City of Huber Heights  
6131 Taylorsville Rd.  
Huber Heights, OH  
45424  
  
937.233.1423  
937.233.1272 fax  
  
[www.hhoh.org](http://www.hhoh.org)

In accordance with the requirement of title II of the Americans with Disabilities Act of 1990 ("ADA"), the City of Huber Heights will not discriminate against qualified individuals with disabilities on the basis of disability in its services, programs, or activities.

**Employment:** The City of Huber Heights does not discriminate on the basis of disability in its hiring or employment practices and complies with all regulations promulgated by the U.S. Equal Employment Opportunity Commission under title I of the ADA.

**Effective Communication:** The City of Huber Heights will generally, upon request, provide appropriate aids and/or services leading to effective communication for qualified persons with disabilities so they can participate equally in the City of Huber Heights' programs, services, and activities, including qualified sign language interpreters, documents in Braille, and other ways of making information and communications accessible to people who have speech, hearing, or vision impairments.

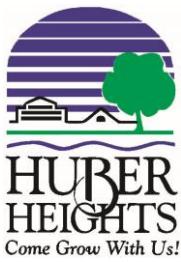
**Modifications to Policies and Procedures:** The City of Huber Heights will make reasonable modifications to policies and programs to ensure that people with disabilities have an equal opportunity to enjoy all of its programs, services, and activities. For example, individuals with service animals are welcomed in the City of Huber Heights offices, even where pets are generally prohibited.

Anyone who requires an auxiliary aid or service for effective communication, or modification of policies or procedures to participate in a program, service, or activity of the City of Huber Heights should contact the office of the HR Director, at 937-237-5847 as soon as possible but no later than 48 hours before the scheduled event.

The ADA does not require the City of Huber Heights to take any action that would fundamentally alter the nature of its programs or services or impose an undue financial or administrative burden.

Complaints that a program, service, or activity of the City of Huber Heights is not accessible to persons with disabilities should be directed to the HR Director, at 937-237-5847.

The City of Huber Heights will not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the cost of providing auxiliary aids/services or reasonable modifications of policy, such as retrieving items from locations that are open to the public but are not accessible to persons who use wheelchairs.



## CITY OF HUBER HEIGHTS GRIEVANCE PROCEDURE UNDER THE AMERICANS WITH DISABILITIES ACT

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This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act of 1990 ("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 Huber Heights. The City of Huber Heights Personnel Policy 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 tape recording of the complaint, will be made available for persons with disabilities upon request.

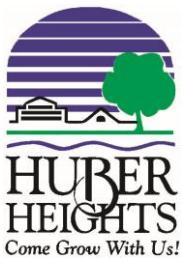
The complaint should be submitted by the grievant and/or his/her designee as soon as possible but no later than 180 calendar days after the alleged violation to: ADA Coordinator, Human Resources Department, 6131 Taylorsville Road, Huber Heights, OH 45424.

Within 15 calendar days after receipt of the complaint, the HR Director, or his/her designee will meet with the complainant to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, the HR Director, or his/her designee will respond in writing, and where appropriate, in a format accessible to the complainant, such as large print, Braille, or audio tape.

If the response by the HR Director or her designee does not satisfactorily resolve the issue, the complainant and/or his/her designee may appeal the decision within 15 calendar days after receipt of the response to the City Manager or his designee.

Within 15 calendar days after receipt of the appeal, the City Manager or his designee will meet with the complainant to discuss the complaint and possible resolutions. Within 15 calendar days after the meeting, the City Manager 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 the HR Director or his/her designee, appeals to the City Manager or his designee, and responses from these two offices will be retained by the City of Huber Heights in the Human Resources Department.



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## CITY OF HUBER HEIGHTS

### AMERICANS WITH DISABILITIES ACT (ADA) TITLE II GRIEVANCE FORM

#### 1. COMPLAINANT INFORMATION:

Name of Complainant:

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Last

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M

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First

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Address

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City

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State

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Zip

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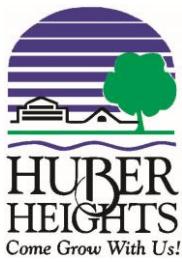
Telephone Number

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E-mail Address

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

Voice Telephone  TTY  E-mail  Other: \_\_\_\_\_

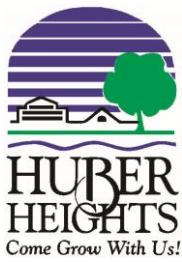


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2. **DESCRIBE YOUR COMPLAINT OF DISCRIMINATION BASED UPON DISABILITY:** Be specific and give date(s), time(s) and location(s). Use the reverse side of this sheet or attach pages if needed.
3. **PERSONS NAMED IN YOUR COMPLAINT:** If applicable, list the names of all persons involved in your complaint. Indicate the job title and City Department if possible.
4. **WITNESSES TO YOUR COMPLAINT:** If applicable, list the names of all person 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.

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Signature

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Date

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

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

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

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

For any questions or concerns, please contact the ADA Coordinator, at  
937.237.5847.