STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Complaint of Discrimination under the Americans with Disabilities Act

To: Division of Parole and Probation Regional (DPP) or Correctional Facility ADA Coordinator

Emergency Request: ☐ Check only if your complaint poses a continued threat to your health, safety, or welfare.

Complainant Name:	Location of Program, Service, or Activity:
Identifying Number (SID, DOC or DPP #):	Date of Complaint:

Subject of Complaint (choose one)**:**

☐ Classification	☐ Program or Service	☐ Complaint Against Staff or Others
☐ Auxiliary Aid or Service	☐ Dietary	☐ Facility or Office Operations
☐ Telephone	☐ Visitation	☐ Other _____

Complaint:

Briefly describe your complaint, including the date of the incident, the persons involved, and the accommodation you are seeking:

_____ _____
Date Signature of Inmate

RECEIPT Case No. _____

RETURN TO: _____
Last Name First Name Middle Initial SID Number Location

I acknowledge receipt of your ADA complaint dated _____. In accordance with Department Directive DPSCS.200.0007 §.06D a response will be provided to you within 30 calendar days of receipt.

_____ _____
Date Signature of ADA Coordinator

Correctional Facility or DPP Regional ADA Coordinator Response to Complaint:

_____ _____

Date Signature of ADA Coordinator

This Section to be Completed by the Department ADA Coordinator If Complaint Unfounded

Date Unfounded Complaint Received: _____		Approved: ☐ Yes ☐ No	
Dept. ADA Coordinator Name (Print)	*Location*	*Signature*	*Date*

Summary of Response and Authorized Determination:

Complaint: ☐ Founded ☐ Unfounded

Name of approving authority for this response and decision:_____

Managing Official, Regional Administrator, Director, or Commissioner

Signature: _____ Date: _____

Distribution: Requesting Individual, Requesting individual's file, Case Manager or Supervising Agent, Facility or Regional ADA Coordinator, Approving Authority, and the Department ADA Coordinator

Reset Form