



AMERICAN WITH DISABILITIES ACT (ADA) COMPLAINT PROCESS

Ben Franklin Transit (BFT) is committed to ensuring that no qualified individual with a disability be discriminated against by BFT, its contractors, nor sub recipients per U.S. Department of Transportation American with Disabilities Act (ADA) of 1990 (49 CFR Parts 27, 37, 38 & 39).

If you feel, by reason of such disability, you (or someone you know) has been excluded from the participation in, been denied the benefits of, or been subjected to discrimination of any BFT transit services, please complete the information below to file your complaint. Complaints must be filed within 180 calendar days of the alleged incident.

How do you file a complaint?

§ 1: Submitting ADA Complaint Form to Ben Franklin Transit

Riders can submit ADA complaints in the following ways:

1. In-person at the Three Rivers Customer Service Center, 7109 W. Okanogan Place, Kennewick
2. Web-Site: Riders can submit online ADA Complaint Form on the Ben Franklin Transit Web-site, bft.org by going to the "Contact Us – Civil Rights"
3. US Mail: Riders can mail ADA Complaint Form to the Ben Franklin Transit, 7109 W. Okanogan Place, Kennewick, WA 99336-2341
4. Telephone: Riders can contact Ben Franklin Transit Customer Service Department at (509) 735-5100 Monday through Friday, 6:00 AM – 6:00 PM, Saturday 8:00 AM – 5:00 PM.
5. E-mail: Riders can submit ADA Complaint Form by e-mailing customercomment@bft.org.
6. Fax: Riders can send ADA Complaint Form by fax to (509) 783-9956

§ 2: Feedback Review Acknowledgement & Investigation Process

All feedback from customers pertaining to the Americans with Disabilities Act is valued and will be reviewed by the ADA Coordinator. After complaint is received, the Customer Service staff or designee will distribute the customer communication to the ADA Coordinator and other the appropriate agency representative(s). All ADA complaints will be tracked separately from other customer feedback to ensure expedited responses.

1. All ADA complaints will be forwarded to the ADA Coordinator. Complainant shall receive an initial response within ten (10) business days provided they submit legible contact information.
2. Investigation of complaint will begin within fifteen (15) days of complaint submittal pending the complaint meets the requirements of ADA discrimination.
3. BFT will complete investigation of valid ADA complaints within sixty (60) calendar dates of original submittal
4. BFT will communicate the findings of the investigation to complainant promptly. Complainant will have five (5) business days from receipt of BFT's response to file an appeal. If no appeal is filed the complaint will be closed.

§ 3: Feedback Assistance

Do you need complaint assistance?

If you are unable to complete a written complaint due to a disability or if information is needed in another language we can assist you. Please contact us at (509) 735-5100.

Si usted no puede hacer una queja por escrito debido a una discapacidad o si necesita información en otro idioma podemos ayudarle. Por favor contáctenos en (509) 735-5100.



AMERICAN WITH DISABILITIES ACT (ADA) COMPLAINT FORM

PLEASE PRINT CLEARLY

SECTION I

Today's Date: _____

Name: _____

Street address: _____

City: _____

State: _____

Zip Code: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email: _____

Do you require an accessible format?

Large Print

TTY/TDD

Audio Tape

Other

SECTION II

Are you filing this complaint on your own behalf?

* Yes

No

** If you answered "yes" to this question, go to Section III*

If not, please supply the name and relationship of the person for whom you are filing:

Name: _____

Relationship: _____

Address of person discriminated against: _____

City: _____

State: _____

Zip Code: _____

Have you obtained permission from this person?

Yes

No

Please explain why you have filed on behalf of this person: _____

SECTION III

If you believe you were discriminated against based on a disability, please provide as much detail concerning the alleged discrimination.

Date of Alleged Discrimination (Month, Day, Year): _____ Time: _____

Type of Transit: Dial A Ride Fixed Route Other: _____

Transit Line / Route: _____ Vehicle ID or Name: _____ Location: _____

Name(s) of Employee(s) involved: _____

Explain as clearly as possible what happened and why you believe you were discriminated against. Use the back of this form if needed for more space.

What type of corrective action would you like to see taken? _____

SECTION IV

Have you previously filed an ADA complaint with BFT? Yes No
BFT Contact Name: _____ Telephone Number: _____

SECTION V

Have you filed this complaint with any other Federal, State, or Local Agency, or with any Federal or State Court?
 Yes No

If Yes, check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Federal Agency: | <input type="checkbox"/> Federal Court: |
| <input type="checkbox"/> State Agency: | <input type="checkbox"/> State Court: |
| <input type="checkbox"/> Local Agency: | <input type="checkbox"/> Local Court: |

Please provide contact information for the person you spoke to at the above Agency:

Name: _____	Title: _____
Agency: _____	Telephone: _____
Address: _____	City: _____ State: _____ Zip: _____

You may attach any written materials or other information that you think is relevant to your complaint.

Your signature and date is required to file this complaint.

Complainants Signature: _____ Date: _____

Please submit this form in person or at the address below, or mail this form to:

Ben Franklin Transit
ADA Eligibility Coordinator
1000 Columbia Park Trail
Richland, WA 99352
(509) 734 5119
(509) 735 4392 (fax)

If information is needed in another language, please call 509-735-5100
Si se necesita información en otro idioma, por favor llame a 509-735-5100

