

**Aster Aging, Inc.**  
**Americans with Disabilities Act and Section 504 of the Rehabilitation**  
**Act of 1973 Discrimination Complaint Form**

Instructions: If you believe Aster Aging has engaged in discrimination against one or more persons based on medical condition or disability, please fill out this form completely, sign, and return to the address on the next page.

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. Call (480) 964-9014 for assistance or TTY at 800-842-4681.

Name of Complainant: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Person Discriminated Against:  
(if other than the complainant) \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

What date did the discrimination occur? \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use additional space on the next page if necessary):

Has a complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court? Yes  No

If yes, Agency or Court: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Filed: \_\_\_\_\_

Additional space for answers:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return Form to:

ADA Coordinator – Human Resources Associate  
Aster Aging  
45 W. University Drive  
Mesa Arizona 85201

Or by email: [HR@asteraz.org](mailto:HR@asteraz.org)  
Phone: 480-964-9014  
Fax: 480-898-7306  
TTY: 800-842-4681