

**State of Hawaii**  
**The Department of Budget and Finance**  
**The Americans with Disabilities Act – Title II**  
**Grievance Form**

COMPLAINANT INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

COMPLAINT SUMMARY

(Provide details of date, time, place, people involved, witnesses and circumstances):

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REQUESTED REMEDY

(Provide corrective action or remedies you are seeking):

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The information provided above is truthful and accurate to the best of my knowledge.

Complainant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail To:

State of Hawaii - The Department of Budget and Finance  
Human Resources Office  
Attn: Lori Ikenaga  
250 S. Hotel St., Suite 307  
Honolulu, HI 96813