NEW YORK STATE | Homeland Security and Emergency Services

Americans With Disabilities Act Complaint Form

Please use this form to file a complaint based on a disability in the provision of services, activities, programs or benefits.
Please send this form to:

Division of Human Resources Management
1220 Washington Ave, Building 7A
Albany, NY 12226
RAInquiries@dhses.ny.gov

Information

Name | **Email** | **Phone**

Address

Your claim is made against:

State Agency

Name | **Title** | **Phone**

Address

Complaint Circumstances

Complaint Location(s) | **Complaint Date(s)**

Are the circumstances of your complaint continuing? ☐ **Yes** ☐ **No**

Please describe the alleged denial of services, activities, programs or benefits and your reason(s) for concluding that the conduct was discriminatory. Please include the name(s) of witnesses, if any, and attach supporting data, if available. Please attach additional pages if needed.

Have you filed a claim regarding this complaint with a federal, state or local government agency? ☐ **Yes** ☐ **No**

Have you hired an attorney with respect to the allegations in the complaint? ☐ **Yes** ☐ **No**

Have you instituted a legal suit or court regarding this complaint? ☐ **Yes** ☐ **No**

This complaint form was completed by: ☐ **Complainant** ☐ **ADA Coordinator**

Signature: _____ **Date:** _____