AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

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

Please submit this form to the Bureau of Human Resources at:

Office of Temporary and Disability Assistance
Bureau of Human Resources
40 North Pearl Street, 12B
Albany, NY 12243
Phone: 518-473-8555
Email: accessibility@otda.ny.gov
Website: Notice under ADA

COMPLAINANT INFORMATION

Name:

Home Address:

Home Phone:

E-mail Address:

1. Your claim is made against:

State Agency:

Name:

Title:

Address:

Phone:

2. Location(s) and date(s) of the circumstances giving rise to your complaint

Are the circumstances of your complaint continuing? Yes: No:

3. 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.

4. A. Have you filed a claim regarding this complaint with a federal, state or local government agency?

Yes: No:

B. Have you hired an attorney with respect to the allegations in the complaint?

Yes: No:

C. Have you instituted a legal suit or court action regarding this complaint

Yes: No:

5. This complaint form was completed by:

ADA Coordinator: Complainant:

Signature: Date: