

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 ADA Coordinator, Office of Human Capital, DASNY, 515 Broadway, Albany, NY 12207; you may find contact information for DASNY's ADA Coordinator at www.DASNY.org.

COMPLAINANT INFORMATION

Na	me:	Home Phone:
Но	me Address:	Email:
1.	Your claim is made against:	
	Public Authority:	
	Name:	
	Title:	
	Address:	
	Phone:	
2.	Location(s) and date(s) of the circumstances giving r	ise to your complaint:
	Are the circumstances of your complaint continuing? ② Yes ② No	

	the alleged denial of services, activities, programs or benefits and for concluding that the conduct was discriminatory. Please include witnesses, if any, and attach supporting data, if available.
4. A. Have you file local governme	ed a claim regarding this complaint with a federal, state or ent agency?
local governme 2 Yes 2 No	
local governme 2 Yes 2 No B. Have you hir 2 Yes 2 No	ent agency?
local governme 2 Yes 2 No B. Have you hir 2 Yes 2 No C. Have you ins 2 Yes 2 No 5. This complaint	ent agency? red an attorney with respect to the allegations in the complaint?