Americans with Disabilities Act Complaint Form

(Updated September 2023)

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

Please submit this form to New York State Office For the Aging's American with Disabilities Act Coordinator:

Colleen Scott
2 Empire State Plaza, 6th Floor, Albany, NY
12223-1251
telephone 1-844-697-6321

e-mail: ADACoordinator@aging.ny.gov

1. Complainant Information

Name:

Home Phone:

Home Address:

Email:

NEW YORK STATE OF OPPORTUNITY. | Office for the Aging

2. Your claim is made against:

State Agency:

Name:

Title:

Address:

Phone:

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

Date	Location

Are the circumstances of your complaint continuing?

☐ Yes ☐ No

NEW YORK STATE OF OPPORTUNITY. | Office for the Aging

4. 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.

5. Additional Questions

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

6. This complaint form was completed by:

☐ ADA Coordinator ☐ Complainant

SIGNATURE:

DATE: