NEW YORK STATE
DEPARTMENT OF PUBLIC SERVICE

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 Department of Public Service ADA Coordinator, Ms. Kristine Herbert; at dps.sm.accessibility@dps.ny.gov.

COMPLAINANT INFORMATION

Name: _____ Home Phone: _____

Home Address: _____ Email: _____

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: _____