This form is to be used by the public to file a claim of discrimination under the Affordable Care Act based on race, color, national origin, creed/religion, age, sex/sexual harassment, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

Please submit this form to the:  Affirmative Action Officer (AAO)   or  Affirmative Action Administrator 3 (AAA 3)
Richard C. Snyder  
Room 2425  
Corning Tower, ESP  
Albany, NY  12237-0013  
or email it to:  richard.snyder@health.ny.gov  
For questions please call:  (518) 473-1703

Complainant Information
Name:  
Home Address:  
Home Phone:  Work Phone: 
Email:  

Details of Claim
☐ Race  ☐ National Origin  ☐ Age
☐ Color  ☐ Sex  ☐ Disability

Your claim of discrimination is made against:
Name of Provider: 
Address:  
Phone:  Date(s) discrimination occurred: 
Is the discrimination continuing?  ☐ Yes  ☐ No
Please describe briefly the alleged discriminatory conduct and your reasons for concluding that the conduct was discriminatory. Please include the names of witnesses, if any, and attach supporting data, if available. Please use additional sheets of paper, if necessary.

Have you filed a claim regarding this complaint with a federal, state or local government entity? □ Yes □ No
Have you instituted a legal suit or court action regarding this complaint? □ Yes □ No
Have you hired an attorney with respect to the allegations in the complaint? □ Yes □ No

Signature of Complainant __________________________________________ Date _________________________