NEW YORK STATE DEPARTMENT OF HEALTH
AMERICANS WITH DISABILITIES ACT (ADA) COMPLAINT

Please complete this form and return to:

Denise DiPace, Esq.
Department of Health
Division of Legal Affairs
Empire State Plaza
Corning Tower, Room 2415
Albany, NY 12237

(Please Print Clearly)

Name of Complainant: _____

Address Where Complainant Currently Resides: _____

_____

_____

Phone Number of Complainant: _____

Complainant's Authorized Representative: _____

Name: _____

Address: _____

Telephone: _____

Medicaid CIN# (if applicable): _____

Location of Local Social Services District (if applicable): _____

Provide a description of the alleged discrimination, including the name of the specific person(s), program(s) and/or facility(ies) the complainant believes is/are responsible for the discrimination. _____
_____
_____
_____
_____
_____
_____

Date of Alleged Discrimination: _____