NEW YORK STATE | Office of Mental Health

Disabilites Act Complaint Form

Please use this form to file a complaint based on disability in the provision of services, activities, programs or benefits. Submit this form to the ADA Coordinator, Matt Canuteson at Matthew.Canuteson@omh.ny.gov. (518) 473-4548

Complaint Information

Name:

Home Phone:

Email:

Home Address:

Street:

City:

State:

Zip Code:

1.Your claim is made against:

State Agency:

Name:

Title:

Address:

Street:

City:

State:

Zip Code:

Phone:

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

Location(s)	Date

Are the circumstances of your complaint continuing?

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 governent agency?

◯ Yes ◯ No

B. Have you hired an attorney with respect to the allegation 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

Signatue Date: