NEW YORK STATE | Department of Taxation and Finance

OFFICE OF DIVERSITY, EQUITY & INCLUSION

WAHC -BUILDING 9-ALBANY, NY 12207

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:

NYS Department of Taxation and Finance
Attn: Designee for Reasonable Accommodation
Building 9, Room 256
W.A. Harriman State Office Campus
Albany, NY 12227
Reasonable.Accommodations@tax.ny.gov

COMPLAINANT INFORMATION

Name:

Home Phone:

Email:

Home Address:

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: _____