AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

NEW YORK STATE OF OPPORTUNITY. Hudson River - Black River Regulating District

Submit to:
John C. Callaghan, Executive Director
Hudson River-Black River Regulating District
575 Broadway, Fl. 3
Albany, NY 12207 / hrao@hrbrrd.ny.gov

Use this form to file a complaint based on disability in the provision of services, activities, programs or benefits.

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: _____