NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Health Insurance Program

Americans with Disabilities Act (ADA) Complaint

Title II of the Americans with Disabilities Act (ADA) is intended to protect qualified individuals with disabilities from discrimination on the basis of disability in the benefits, programs and services provided by all state and local governments.

The Federal Government defines "qualified individual with a disability" as "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, ..., or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." All state and local government programs and the services and/or benefits provided by or through those programs that receive Federal assistance must comply with Title II of the ADA.

Please be advised that employment related ADA complaints do not fall within the scope of Title II.

The New York State Department of Health (DOH) administers, regulates and/or provides funding to a number of health insurance and other health programs throughout the State. These programs include, but are not limited to, Medicaid, Family Health Plus, and Child Health Plus.

If you are receiving a benefit, program or service that is administered, funded, or regulated by DOH and you feel you have been discriminated against on the basis of disability, you may fill out the complaint form below and mail it to the address listed on the form. Alternatively, you may send a letter stating your complaint and including all of the information requested in the complaint form.

Please complete this form and return to:

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

Please Print Clearly

Complainant

Name _____

Address Where Complainant Currently Resides

_____

_____

Telephone _____

Complainant's Authorized Representative

Name _____

Address _____

_____

Telephone _____

Medicaid CIN # (if applicable) _____

Location of Local Social Services District (if applicable) _____

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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.

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Date of Alleged Discrimination _____