



# Department of State

**New York State  
Department of State  
Division of Affirmative Action Programs**  
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## Access to Services in Your Language: Complaint Form

New York State's policy is to take reasonable steps to overcome language barriers to public services and programs.

To do this, our goal is to **talk to you in your language and provide vital forms and documents in English, Spanish, Chinese, Haitian Creole, Italian, Korean and Russian.**

Your comments on this form will help us towards that goal. **All information is confidential.**

**Please print, and sign the form with black ink. Then send it by mail, fax or email to the address written above.**

**Person making the complaint:** Claimant ID # (if available): \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_

City, Town or Village: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Preferred language: \_\_\_\_\_ E-mail address (if available): \_\_\_\_\_

Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

**Is someone else helping you file this complaint?**  Yes (If 'Yes', include their name below)  No

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

**What was the problem?** Check all the boxes that apply.

I was not offered an interpreter

I asked for an interpreter and was denied

The interpreter(s) or translator(s) skills were not good

The interpreter(s) made rude or inappropriate comments

The services took too long

I was not given forms or notices in a language I can understand (List documents needed below)

I was unable to use services, programs or activities (Explain below)

Other: \_\_\_\_\_ Use additional pages if needed.

**When did problem happen?** Date (MM/DD/YYYY): \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

**Where did problem happen?** \_\_\_\_\_

**Describe what happened.** Please be specific. Use additional pages as needed. Print your name on each sheet.  
 List language, services and documents needed. Include names, addresses and phone numbers of people involved, if known.

**Did you complain to anyone from the Department/Agency? Who and what was the response?** Please be specific.

**I certify that this statement is true to the best of my knowledge and belief.**

**Signature:** \_\_\_\_\_ **Date (MM/DD/YYYY):** \_\_\_\_\_  
 (Person making the complaint)

**Do not write in this box. For office use only**

Date: \_\_\_\_\_ Reviewer: \_\_\_\_\_

Resolution: \_\_\_\_\_