External Discrimination Complaint Form

This form is to be used by the public to file a claim of discrimination under the Affordable Care Act based on race, color, national origin, creed/religion, age, sex/sexual harassment, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

Please submit this form to the:
Affirmative Action Administrator 3 (AAA 3)
LaShanna Frasier
Room 2511
Corning Tower, ESP
Albany, NY 12237-0013

or email it to: LaShanna.Frasier@health.ny.gov.

For questions please call: (518) 473-7883

Complainant Information

Name: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Email: _____

Details of Claim

- ☐ Race
- ☐ Color
- ☐ National Origin
- ☐ Sex
- ☐ Age
- ☐ Disability

Your claim of discrimination is made against:

Name of Provider: _____

Address: _____

Phone: _____ Date(s) discrimination occurred: _____

Is the discrimination continuing? ☐ Yes ☐ No

Please describe briefly the alleged discriminatory conduct and your reasons for concluding that the conduct was discriminatory. Please include the names of witnesses, if any, and attach supporting data, if available. Please use additional sheets of paper, if necessary.

Have you filed a claim regarding this complaint with a federal, state or local government entity? ☐ Yes ☐ No

Have you instituted a legal suit or court action regarding this complaint? ☐ Yes ☐ No

Have you hired an attorney with respect to the allegations in the complaint? ☐ Yes ☐ No

Signature of Complainant _____ Date _____