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 the ADA Coordinator, Barbara Ann Dillon, at 333 Earle Ovington Blvd., Suite 403, Uniondale, New York 11553 or bdillon@lipower.org.

COMPLAINANT INFORMATION

Name: ____________________________ Home Phone: ____________________________

Home Address: ____________________________ Email: ____________________________

1. Your claim is made against:

Governmental Agency: Long Island Power Authority

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.

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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: