New York State Office of Mental Health
44 Holland Avenue
Albany New York 12229
Email: culturalcompetencebureau@omh.ny.gov

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: 1) Talk to you in your language and 2) Provide vital forms and documents in the top six, most frequently used languages, in addition to English.
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 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 No If 'Yes', include their:

First name: _____ Last name: _____

What was the problem? Check all the boxes that apply and explain below.

- I was not offered an interpreter
- I asked for an interpreter and was denied
- The interpreter(s) or translator(s) skills were not good (List their names, if known)
- The interpreter(s) made rude or inappropriate comments
- The services took too long (Explain below)
- 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 (Explain below)

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:

LA 1 (09/12)