# GRIEVANCE PROCEDURE UNDER THE AMERICANS WITH DISABILITIES ACT

This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act of 1990 ("ADA"). It may be used by anyone who wishes to file a complaint alleging discrimination on the basis of disability in the provision of services, activities, programs, or benefits by NYSIF. Employment-related complaints of disability discrimination are covered elsewhere, in policies available from the human resources office of NYSIF.

The complaint should be in writing and contain information about the alleged discrimination such as name, address, phone number of complainant and location, date, and description of the problem. No particular format of the complaint is required. Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint, will be made available for persons with disabilities upon request.

The complaint should be submitted by the grievant and/or his or her designee as soon as possible but no later than 60 calendar days after the alleged violation to:

**Isaac Okafor**
Designee for Reasonable Accommodation and ADA Coordinator
199 Church St.
New York, NY  10007
E-mail address:  iokaf@nysif.com
Telephone number:  212-312-9813

Within 15 calendar days after receipt of the complaint, the ADA Coordinator or his or her designee will meet with the complainant to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, the ADA Coordinator or his or her designee will respond in writing, and where appropriate, in a format accessible to the complainant, such as large print, Braille, or audio tape. The response will explain the position of NYSIF and offer options for substantive resolution of the complaint.

If the response by the ADA Coordinator or his or her designee does not satisfactorily resolve the issue, the complainant and/or his or her designee may appeal the decision within 15 calendar days after receipt of the response to NYSIF's head or his or her designee.

Within 15 calendar days after receipt of the appeal, NYSIF's head or his or her designee will respond in writing, and, where appropriate, in a format accessible to the complainant, with the agency's final resolution of the complaint, or indicating that the matter has been returned to the ADA Coordinator for further action.  If further action is indicated, the complainant will be contacted within 15 days from the written response.

All written complaints received by the ADA Coordinator or his or her designee, appeals to NYSIF's head or his or her designee, and responses from these two offices will be retained by NYSIF for at least three years.

# NYSIF

# 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. If you have questions about this form, please contact Isaac Okafor at iokaf@nysif.com or by telephone at 212-312-9813.

Please submit this form to:

**Isaac Okafor, ADA Coordinator, New York State Insurance Fund, 199 Church Street, New York, NY 10007**

Name: _____  Home Phone: _____

Email: _____

Home Address: _____

1.  Your claim is made against:     **NYS AGENCY:** _____

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.

_____

4.  Have you filed a claim regarding this complaint with a federal, state or local government agency?

Yes ☐     No ☐

Have you hired an attorney with respect to the allegations in the complaint?

Yes ☐     No ☐

Have you instituted a legal suit or court action regarding this complaint?

Yes ☐     No ☐

5.  This complaint form was completed by:

ADA Coordinator ☐     Complainant ☐     Other (explain) ☐     _____

**SIGNATURE :** _____     DATE: _____