

Wyoming County Community Hospital/SNF ADA Complaint Policy and Procedures

POLICY

The Americans with Disabilities Act of 1990 (ADA) prohibits discrimination on the basis of a disability. Wyoming County Community Hospital/SNF shall not exclude an individual with a disability, from participating in or be denied the benefits of the services, programs, activities, transit system or a facility. Wyoming County Community Hospital/SNF will not discriminate against individuals with disabilities. Any person who believes that they have been discriminated against, or denied access to our services, programs, activities, transit system or facilities because of their disability may submit a complaint directly to the Wyoming County Community Hospital/SNF.

COMPLAINT PROCEDURES

A written complaint should be made within 30 calendar days of the alleged incident to facilitate a prompt investigation and resolution. The written complaint should be as specific as possible and include the date the incident occurred, names of individuals involved, the facility, programs, services or activities involved, the nature of the problem and a proposed resolution. Include your full name, contact information and best method to reach you.

Mail or email the complaint to:

Justin Bayliss, Title IV/ADA Coordinator
Wyoming County Community Hospital/SNF
400 N Main St
Warsaw, NY 14569
(585) 786-2233
jbayliss@wcchs.net

If you need an alternative method to provide your complaint, you may contact the ADA Coordinator and either provide a verbal complaint or request information in accessible formats to be able to submit your complaint.

Within 10 days after receipt of the complaint, the ADA Coordinator will contact the complainant, by mail, email, telephone or video conference, to discuss the complaint and to find a resolution. Within 30 calendar days of the discussion, the ADA Coordinator will provide a written explanation on the outcome of the complaint. A summary of the complaint and its closure will be kept for five years.

If the complainant is not satisfied with the outcome, the complainant, may appeal the decision, within 45 days to New York State Department of Transportation (see below).

As an alternative to filing an ADA complaint directly with the Wyoming County Community Hospital/SNF, a complaint may be submitted directly to:

- New York State Department of Transportation
Office of Diversity and Opportunity
50 Wolf Road, 6th Floor
Albany, NY 12232
(518) 457-1129 Fax (518) 549-1273
OCR-TitleVI@dot.ny.gov
- Federal Transit Administration
Office of Civil Rights
Attention: Title VI Program Coordinator
East Building, 5th Floor-TCR,
1200 New Jersey Ave., SE Washington,
DC 20590

Questions concerning this policy and procedures may be directed to the Wyoming County Community Hospital/SNF, Program Director at (585)786-2233 or at jbayliss@wcchs.net.

Wyoming County Community Hospital/SNF Title VI and ADA Complaint Form

Section I:					
Your Name:					
Address:					
Telephone (Home):			Telephone (Work/Mobile):		
Email Address:					
Accessible Format Requirements?	Large Print			Audio Tape	
	TDD			Other	
Section II:					
Are you filing this complaint on your own behalf?			Yes*		No
<i>*If you answered "yes" to this question, go to Section III.</i>					
If not, please supply the name and relationship of the person for whom you are complaining:					
Please explain why you have filed for a third party:					
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.			Yes		No
Section III:					
I believe the discrimination I experienced was based on (check all that apply):					
☐ Race ☐ Color ☐ National Origin ☐ Disability					
Date of Alleged Discrimination (Month, Day, Year): _____					
Agency name complaint is against: _____					
Location of where the alleged discrimination occurred:- _____					
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please attach additional pages. _____ _____ _____ _____ _____					

Section IV	
Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court? ☐ Yes ☐ No <i>If yes, check all that apply:</i> ☐ Federal Agency: _____ ☐ Federal Court: _____ ☐ State Agency: _____ ☐ State Court: _____ ☐ Local Agency: _____	
Provide information for the contact person at the agency/court where the complaint was filed.	
Name and Title:	

Agency:	
Address:	
Telephone:	

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date required below.

Signature

Date

Please submit this form by mail, email or in person to the address below.

Wyoming County Community Hospital/SNF
 Justin Bayliss, Title VI/ADA Coordinator
 400 N Main Street
 Warsaw, NY 14569
 Jbayliss@wcchs.net

This complaint may also be filed directly with the New York State Department of Transportation, Office of Civil Rights, 50 Wolf Road, 6th Floor, Albany, NY 12232, (518) 457-1129 Fax (518) 549-1273, OCR-TitleVI@dot.ny.gov or the Federal Transit Administration, Office of Civil Rights, Attention: Title VI Program Coordinator, East Building, 5th Floor-TCR, 1200 New Jersey Ave., SE Washington, DC, 20590.