New York State Division of Veterans' Affairs

LANGUAGE ACCESS COMPLAINT FORM

YOUR FIRST NAME	YOUR LAST NAME	
HOME PHONE	OTHER PHONE	
STREET ADDRESS		CITY, TOWN, OR VILLAGE
STATE	ZIP CODE	E-MAIL ADDRESS (if available)

Is someone else filing this complaint for you? YES ☐ NO ☐

If Yes, include their name.

FIRST NAME _____ LAST NAME _____

Nature of the problem:

☐ Was not provided interpretation services

☐ Interpreters or translators were not competent

☐ Services were not timely

☐ Was not provided translated vital document(s)

☐ Was unable to access services, programs or activities

☐ Other:

Describe briefly what happened. Please provide specific names and addresses where possible. (Attach additional pages as needed.)

How did you and the agency attempt to resolve the problem? Please be as specific as possible.
I certify that this statement of my complaint above and on any pages attached is true to the best of my knowledge and belief. SIGNATURE _____ DATE (MM/DD/YYYY) _____