UNITED STATE DEPARTMENT OF
HEALTH AND HUMAN SERVICES

DISABILITY RIGHTS NEW YORK,

Complainant,

-against-

NEW YORK STATE DEPARTMENT OF
HEALTH

Respondent.

OCR CASE NO:

COMPLAINT

PRELIMINARY STATEMENT

1. In November 2015 the New York State Task Force on Life and the Law ("Task Force") and the New York State Department of Health ("NY DOH") published Ventilator Allocation Guidelines ("Guidelines") in order to provide guidance on how to "ethically allocate limited resources (i.e. ventilators) during a severe influenza pandemic while saving the most lives." *Ventilator Allocation Guidelines* (New York State Task Force on Life and the Law, New York State Department of Health, Nov. 2015).
2. Howard A. Zucker, New York State Commissioner of Health, stated that the Guidelines "provide an ethical, clinical, and legal framework to assist health care providers and the general public in the event of a severe influenza pandemic." *Id.* "Letter from the Commissioner of Health."
3. Upon information and belief, the Guidelines are being reviewed and potentially revised by the Department of Health in order to ensure they best effectuate their goals as stated above.

4. The Guidelines, as written, contain serious gaps which discriminate against people with preexisting disabilities and place them in potentially life-threatening positions in violation of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, *et seq*., and Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794, *et seq*.
5. The Guidelines, as written, will have the unintended consequence of disproportionately disqualifying many people with disabilities from ventilator access simply because they have underlying conditions that may intensify symptoms and slow recovery, which violates both the ADA and Section 504.
6. On March 26, 2020, Disability Rights New York ("DRNY") sent a letter to Andrew Cuomo, Governor of the State of New York, requesting that the New York State Department of Health ("NY DOH") issue clear guidance regarding the potential for discrimination against people with disabilities seeking medical care during the COVID-19 pandemic.

JURISDICTION

7. The Office of Civil Rights of the United States Department of Health and Human Services has subject matter jurisdiction over claims of discrimination against State health care agencies as well as programs and activities to whom the Department provides federal assistance.

PARTIES

8. Disability Advocates, Inc. is an independent non-profit corporation organized under the laws of the State of New York. Disability Advocates, Inc. is authorized to conduct business under the name Disability Rights New York ("DRNY").

9. DRNY is a Protection and Advocacy system ("P&A"), as that term is defined under the Developmental Disabilities Assistance and Bill of Rights Act ("DD Act"), 42 U.S.C. § 15041 *et seq.*, the Protection and Advocacy for Individuals with Mental Illness Act of 1986 ("PAIMI Act"), 42 U.S.C. § 10801 *et seq*., and the Protection and Advocacy of Individual Rights Act ("PAIR Act"), 29 U.S.C. § 794e *et seq*. with offices in the State of New York located at: 25 Chapel Street, Suite 1005, Brooklyn, NY 11201; 725 Broadway, Suite 450, Albany, NY 12208; and 44 Exchange Blvd., Suite 110, Rochester, NY 14614.
10. As New York State's Protection & Advocacy system, DRNY is specifically authorized to pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of individuals with disabilities. 42 U.S.C. § 15043(a) (2)(A) (i); N.Y. Exec. Law § 558(b).
11. Pursuant to the authority vested in it by Congress to file claims of abuse, neglect, and rights violations on behalf of individuals with disabilities, DRNY brings claims on behalf of individuals with disabilities who are currently seeking or may seek acute medical care during the COVID-19 pandemic.
12. New York State is a public entity as defined by 42 U.S.C § 12131(1)(A).
13. New York State operates the New York State Department of Health ("NY DOH").
14. NY DOH is a program or activity of New York State pursuant to 28 C.F.R. § 35.130.
15. NY DOH has a mission to protect, improve and promote the health, productivity and well-being of all New Yorkers, and is responsible for issuing guidance to healthcare providers pursuant to its mission.
16. NY DOH is located at Corning Tower at the Empire State Plaza in Albany, NY 12237.

STATEMENT OF FACTS

New York State Ventilator Allocation Guidelines

17. The NY DOH is "empowered to issue voluntary, non-binding guidelines for health care workers and facilities; such guidelines are readily implemented and provide hospitals with an ethical and clinical framework for decision-making." *Ventilator Allocation Guidelines*, p. 8.

18. "A pandemic that is especially severe with respect to the number of patients affected and the acuity of illness will create shortages of many health care resources, including personnel and equipment. Specifically, many more patients will require the use of ventilators than can be accommodated with current supplies." *Id.* at 1.

19. "To ensure that patients receive the best care possible in a pandemic, a patient's attending physician does not determine whether his/her patient receives (or continues) with ventilator therapy; instead a triage officer or triage committee makes the decision." *Id.* at 5.

20. "While the attending physician interacts with and conducts the clinical evaluation of a patient, a triage officer or triage committee does not have any direct contact with the patient. Instead, a triage officer or triage committee examines the data provided by the attending physician and makes the determination about a patient's level of access to a ventilator." *Id.*

21. "This role sequestration allows the clinical ventilator allocation protocol to operate smoothly. The decision regarding whether to use either a triage officer or committee is left to each acute care facility (i.e., hospital) because available resources will differ at each site." *Id.*

22. NY DOH's Guidelines provide that "an allocation protocol should utilize clinical factors only to evaluate a patient's likelihood of survival and to determine the patient's access to ventilator therapy." *Id.*

23. For the ventilator allocation protocols, "there are three steps: (1) application of exclusion criteria, (2) assessment of mortality risk, and (3) periodic clinical assessments ("time trials")" conducted by a patient's attending physician. *Id.* at 6.

24. "In Step 1, patients who do not have a medical condition that will result in immediate or near-immediate mortality even with aggressive therapy are eligible for ventilator therapy." *Id.*

25. Step 1 applies the "List of Exclusion Criteria for Adult Patients Medical Conditions that Result in Immediate or Near-Immediate Mortality Even with Aggressive Therapy," which includes: "Cardiac arrest: unwitnessed arrest, recurrent arrest without hemodynamic stability, arrest unresponsive to standard interventions and measures; trauma-related arrest; Irreversible age-specific hypotension unresponsive to fluid resuscitation and vasopressor therapy; Traumatic brain injury with no motor response to painful stimulus; Severe burns: where predicted survival ≤ 10% even with unlimited aggressive therapy; Any other conditions resulting in immediate or near-immediate mortality even with aggressive therapy." *Id.* at 57.

26. "In Step 2, patients who have a moderate risk of mortality and for whom ventilator therapy would most likely be lifesaving are prioritized for treatment." *Id.* at 6.

27. "In Step 3, official clinical assessments at 48 and 120 hours after ventilator therapy has begun are conducted to determine whether a patient continues with this treatment." *Id.*

28. “Triage decisions are made based on ongoing clinical measures and data trends of a patient’s health condition, consisting of: (1) the overall prognosis estimated by the patient’s clinical indicators, which is indicative of mortality risk by revealing the presence (or likelihood), severity, and number of acute organ failure(s), and (2) the magnitude of improvement or deterioration of overall health, which provides additional information about the likelihood of survival with ventilator therapy.” *Id.*
29. “Thus, the guiding principle for the triage decision is that the likelihood of a patient’s continuation of ventilator therapy depends on the severity of the patient’s health condition and the extent of the patient’s medical deterioration. In order for a patient to continue with ventilator therapy, s/he must demonstrate an improvement in overall health status at each official clinical assessment.” *Id.*
30. “At Steps 2 and 3, a triage officer/committee examines a patient’s clinical data and uses this information to assign a color code to the patient. The color (blue, red, yellow, or green) determines the level of access to a ventilator.” *Id.*
31. “Blue code patients (lowest access/palliate/ discharge) are those who have a medical condition on the exclusion criteria list or those who have a high risk of mortality and these patients do not receive ventilator therapy when resources are scarce.” *Id.* at 6-7.
32. “[I]f more resources become available, patients in the blue color category, or those with exclusion criteria, are reassessed and may be eligible for ventilator therapy.” *Id.* at 7.
33. “Red code patients (highest access) are those who have the highest priority for ventilator therapy because they are most likely to recover with treatment (and likely to not recover without it) and have a moderate risk of mortality.” *Id.*

34. “Patients in the yellow category (intermediate access) are those who are very sick, and their likelihood of survival is intermediate and/or uncertain. These patients may or may not benefit (i.e., survive) with ventilator therapy. They receive such treatment if ventilators are available after all patients in the red category receive them.” *Id.*

35. “Patients in the green color code (defer/discharge) are those who do not need ventilator therapy.” *Id.*

36. “In some circumstances, a triage officer/committee must select one of many eligible red color code patients to receive ventilator therapy. A patient’s likelihood of survival (i.e., assessment of mortality risk) is the most important consideration when evaluating a patient.” *Id.*

37. “However, there may be a situation where multiple patients have been assigned a red color code, which indicates they all have the highest level of access to ventilator therapy, and they all have equal (or near equal) likelihoods of survival. If the eligible patient pool consists of *only adults* or *only children*,[1] a randomization process, such as a lottery, is used each time a ventilator becomes available because there are no other evidence-based clinical factors available to consider. Patients waiting for ventilator therapy wait in an eligible patient pool.” *Id.* (emphasis in original).

38. “In addition, there may be a scenario where there is an incoming red code patient(s) eligible for ventilator therapy and a triage officer/committee must remove a ventilator

[1] “Because of a strong societal preference for saving children, the Task Force recommended that *young* age may be considered as a tie-breaking criterion in limited circumstances. When the pool of patients eligible for ventilator therapy includes both adults and children (17 years old and younger), the Task Force determined that when all available clinical factors have been examined and the probability of mortality among the pool of patients has been found equivalent, only then may young age be utilized as a tie-breaker to select a patient for ventilator therapy.” *Ventilator Allocation Guidelines*, p. 5.

from a patient whose health is not improving. In this situation, first, patients in the blue category (or the yellow category if there are no blue code patients receiving ventilator therapy) are vulnerable for removal from ventilator therapy if they fail to meet criteria for continued ventilator use." *Id.*

39. "If the pool of ventilated patients vulnerable for removal consists of *only adults* or *only children*, a randomization process, such as a lottery, is used each time to select the (blue or yellow) patient who will no longer receive ventilator therapy." *Id.* (emphasis in original).
40. "A patient may only be removed from a ventilator after an official clinical assessment has occurred or where the patient develops a medical condition on the exclusion criteria list. However, if all ventilated patients are in the red category (i.e., have the highest level access), *none* of the patients are removed from ventilator therapy, even if there is an eligible (red color code) patient waiting". *Id.* (emphasis in original).
41. "Patients who have a medical condition on the exclusion criteria list or who no longer meet the clinical criteria for continued ventilator use receive alternative forms of medical intervention and/or palliative care. The same applies to patients who are eligible for ventilator therapy but for whom no ventilators are currently available." *Id.*
42. "Alternative forms of medical intervention, such as other methods of oxygen delivery and pharmacological antivirals, should be provided to those who are not eligible or waiting for a ventilator." *Id.*

ADA and Section 504 Implications Due to Implicit Bias

43. In creating the Guidelines, "the Task Force concluded that an allocation protocol should utilize clinical factors only to evaluate a patient's likelihood of survival and to determine the patient's access to ventilator therapy." *Id.* at 5.

44. However, in its March 26, 2020, letter DRNY expressed urgent concern that hospitals and medical providers would not act in accordance with the non-discrimination mandates of the ADA and Section 504 and solely utilize clinical factors unless they were explicitly instructed to be aware of potential implicit bias against persons with disabilities.

45. While the Task Force bases its definition of "survival" on the short-term likelihood of survival of the acute medical episode, *id.* at 55, without explicit instruction on frequent implicit bias against the disability community, people with disabilities are likely to be disproportionally categorized as having a condition that falls into the "exclusion criteria" simply because they have underlying conditions which may intensify symptoms and slow recovery.

46. During Step 2 of the triage process, the Task Force states that the Sequential Organ Failure Assessment ("SOFA") system should be used. *Id.* at 57.

47. A SOFA score, which is used to track a person's status during an intensive care stay adds points based on clinical measures of function in six key organs and systems: lungs, liver, brain, kidneys, blood clotting, and blood pressure. *Id.* at 58.

48. Using SOFA, each variable is measured on a zero to four scale, with four being the worst score. A perfect SOFA score, indicating normal function in all six categories, is 0; the worst possible score is 24 and indicates life-threatening abnormalities in all six systems. *Id.*

49. While a SOFA score is based solely on clinical factors and does not take into account personal values or subjective judgments, individuals with preexisting conditions are by default going to receive higher (worse) SOFA scores than individuals without disabilities, meaning these individuals with disabilities will be less likely to receive life-saving care.
50. Individuals with disabilities may live day-to-day without any complications, but with a condition that presents abnormalities in one or more of the six key organs and systems measured using SOFA.
51. These individuals would be disadvantaged in a triage situation prior to considering any symptoms that result directly from COVID-19.
52. The Task Force Acknowledges this fact: "For most patients who are sick with only influenza and have no other comorbidities, the single organ failure is limited to their lungs, which gives them a low SOFA score. However…a patient may also have a comorbidity(s) that affects another organ system(s) which will increase his/her SOFA score." *Id.* at 59.
53. In its March 26, 2020, letter DRNY requested that the following be included in any updated guidance NY DOH provides to healthcare practitioners in order to avoid potentially discriminatory outcomes:
    a. Treatment allocation decisions must be made based on individualized determinations, using current objective medical evidence, and not based on generalized assumptions about a person's disability.
    b. Treatment allocation decisions cannot be made based on misguided assumptions that people with disabilities experience a lower quality of life, or that their lives are not worth living.

c. Treatment allocation decisions cannot be made based on the perception that a person with a disability has a lower prospect of survival. While the possibility of a person's survival may receive some consideration in allocation decisions, that consideration must be based on the prospect of surviving the condition for which the treatment is designed—in this case, COVID-19—and not other disabilities.

d. Treatment allocation decisions cannot be made based on the perception that a person's disability will require the use of greater treatment resources. Reasonable modifications must be made where needed by a person with a disability to have equal opportunity to benefit from the treatment.

54. Without this guidance, NY DOH would allow inevitable implicit biases against people with disabilities to gravely impact their access to potentially life-sustaining care.

Denial of Equal Access to Acute Healthcare Services

55. In its March 26, 2020, letter, DRNY also described the spreading fear of accessing acute healthcare among chronic ventilator users as a result of the Guidelines.

56. Chronic ventilator users contacted DRNY to state that they are afraid to seek acute medical care if they become ill during the COVID-19 pandemic because the Guidelines allow their personal, every-day ventilator to be re-allocated to another individual who is deemed higher priority per the Guidelines. These individuals have also expressed a fear of forcible extubation, which would likely result in death.

57. While some chronic ventilator users in New York live in facilities, thousands of other live independently in the community, realizing the ideal embodied in the right of a person with a disability to live with the greatest autonomy and independence possible.

58. "The Task Force concurred that community-dwelling persons should not be denied access to their ventilators and the Guidelines are only applied to these patients upon their arrival at an acute care facility," *id.* at 42, which leaves chronic ventilator users who live in the community afraid to seek any type of medical care.

59. The chilling effect described above comes from the Task Force's determination that "ventilator-dependent chronic care patients are subject to the clinical ventilator allocation protocol only if they arrive at an acute care facility for treatment. Once they arrive at a hospital, they are treated like any other patient who requires ventilator therapy." *Id.* at 5.

60. "All acute care patients in need of a ventilator, whether due to influenza or other conditions, are subject to the clinical ventilator allocation protocol. Ventilator-dependent chronic care patients are only subject to the clinical ventilator allocation protocol if they arrive at an acute care facility." *Id.* at 6.

61. The Task Force acknowledged that "to triage patients in chronic care facilities once the Guidelines are implemented may theoretically maximize resources and result in more lives saved, [it] conflicts with the societal norm of defending vulnerable individuals and communities." *Id*. at 41. However, it inexplicably withdraws this "defense" the moment a vulnerable individual seeks necessary acute medical care. *Id.*

62. Further, while "[p]atients using ventilators in chronic care facilities are not subject to the clinical protocol," chronic ventilator users who live and thrive in our communities have no such sense of security in their personal assistive technology and are not afforded the access to daily medical care that individuals in facilities have. *Id.* at 40.

63. Perhaps most inexplicably, the Task Force acknowledges the danger its Guidelines pose:

> Chronically ill patients are vulnerable to the pandemic, and chronic care facilities should be able to provide more intensive care on site as part of the

general emergency planning process of expanding care beyond standard locations. These facilities should implement procedures that would treat these patients onsite as much as possible so that only urgent cases are sent to acute care facilities. Barriers to transfer are appropriate and likely during a phase in which acute care hospitals are overwhelmed.

However, this approach may be problematic because it may not provide equitable health care to person with disabilities, *and may place ventilator-dependent individuals in a difficult position of choosing between life-sustaining ventilation and urgent medical care.* Some argued that this strategy was contrary to the aim of saving the most lives because denying ventilator therapy to a ventilator-dependent person is different from denying the ventilator to someone who has a high probability of mortality who might have qualified for a ventilator under non-pandemic circumstances. Thus, *if the ventilator is removed from a person known to depend upon it, s/he will not survive, regardless of the reason requiring hospitalization.*

The Task Force examined the alternative approach, which requires assessing all intubated patients, whether in acute or chronic care facilities, by the same set of criteria. This method does not violate the duty to steward resources and subjects all patients, not just the acutely ill, to a modified medical standard of care. Depending on the design of the criteria, the result might be likely fatal extubations of stable, long-term ventilator-dependent patients in chronic care facilities. The proposed justification for such a strategy is that more patients could ultimately survive if these ventilators were instead allocated to the previously healthy individuals of the influenza pandemic. *This strategy, however, makes victims of the disabled. This approach fails to follow the ethical principle of duty to care and could be construed as taking advantage of a very vulnerable population. More patients might survive, but they would be also different types of survivors, i.e., none of the survivors would be from the disabled community.* The Task Force concluded that such a strategy relies heavily upon ethically unsound judgments based on third-party assessments of quality of life…..

Furthermore, if chronic care patients become so ill that they must be transferred to an acute facility, they may not be eligible for ventilator therapy and lose access to the ventilator at that point. The ventilator may eventually enter the wider pool without prospectively triaging these patients at chronic care facilities. Therefore, the ventilators in chronic care facilities should remain there for *the chronically ill, who are likely to have severely limited access to ventilators in acute care facilities,* which offers an appropriate balance between the duties to care and to steward resources wisely.

Id. at 41-42 (emphasis added).

64. Despite this acknowledgement, and the statement that they examined "the alternative approach," the Task Force fails to even consider providing guidance that does not, under any circumstances, remove a chronic ventilator user from their ventilator without another device being readily available for their use. This is the only acceptable approach.

65. While few could imagine a justification for taking life-sustaining insulin injections from one Type-1 diabetic and providing it to another Type-1 diabetic with a better triage score, NY DOH has made an analogous decision for chronic ventilator users who live in the community and seek acute medical care.

66. In its effort to treat everyone equally, the Task Force seemingly accepts the inevitable deaths of chronic ventilator users:

> While a policy to triage upon arrival may deter chronic care patients from going to an acute care facility for fear of losing access to their ventilator, it is unfair and in violation of the principles upon which this allocation scheme is based to allow them to remain on a ventilator without assessing their eligibility. Distributive justice requires that all patients in need of a certain resource be treated equally; if chronic care patients were permitted to keep their ventilators rather than be triaged, the policy could be viewed as favoring this group over the general public.

Id. at 42.

67. Such a conclusion is against decades of case law and public policy surrounding the ADA and Section 504. Reasonable accommodations will necessarily require that an entity treat an individual with a disability differently, but such differences are necessary to achieve society's equal opportunity goals, and allow individuals with disabilities to enjoy the same benefits and services as their non-disabled peers.

68. DRNY requested that the Guidelines contain explicit guidance to healthcare providers that a chronic ventilator user should never be removed from ventilation support for reasons of rationing.

69. A chronic ventilator user should never be disconnected from ventilation support without a new device being readily available for their use.

70. Without explicit changes in the Guidelines to state that such actions are never acceptable, NY DOH is discriminatorily preventing chronic ventilator users from seeking acute healthcare services in violation of federal law.

FIRST CLAIM FOR RELIEF
TITLE II OF THE AMERICANS WITH DISABILITIES ACT
42 U.S.C. § 12101, *et seq.*

71. DRNY incorporates by reference each and every allegation contained in the foregoing paragraphs as if specifically alleged herein.

72. Title II of the ADA states, in pertinent part:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or subjected to discrimination by any such entity. 42 U.S.C. § 12132.

73. A "public entity" includes state and local government, their agencies, and their instrumentalities. 42 U.S.C. § 12131(1).

74. NY DOH was, at all times relevant to this action, and currently is a "public entity" within the meaning of Title II of the ADA.

75. NY DOH provided and provides "services, programs [and] activities" through their office. 28 C.F.R. § 35.130.

76. The term "disability" includes physical and mental impairments that substantially limit one or more major life activities. 42 U.S.C. § 12102(2).

77. A “qualified individual with a disability” is a person “who, with or without reasonable modification to rules, policies or practices … meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” 42 U.S.C. § 12131(2).

78. People with disabilities who seek acute medical care in New York State are qualified individuals under the ADA.

79. NY DOH’s Guideline violate Title II of the ADA and its implementing regulations by authorizing or failing to forbid actions that:

    a. Deny a qualified individual with a disability the benefits of the services, programs, or activities of a public entity because of the individual’s disability. 42 U.S.C. § 12132.

    b. “Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program.” 28 C.F.R. § 35.130(b)(1)(v).

    c. “[L]imit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.” 28 C.F.R. § 35.130(b)(1)(vii).

    d. “[D]eny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.” 28 C.F.R. § 35.130(b)(2).

e. “Directly or through contractual or other arrangements, utilize criteria or other methods of administration: (i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or (iii) That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.” 28 C.F.R. § 35.130(b)(3).

f. Fail to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” 28 C.F.R. 35.130(b)(7).

g. “Impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.” 28 C.F.R. 35.130(b)(8).

80. As a result of NY DOH’s acts and omissions, individuals with disabilities seeking acute medical care in New York State have and will continue to be denied equal access to the benefits of the services, programs and activities of the healthcare system adhering to the NY DOH Guidelines.

SECOND CLAIM FOR RELIEF
SECTION 504 OF THE REHABILITATION ACT OF 1973
29 U.S.C. § 794

81. DRNY incorporates by reference each and every allegation contained in the foregoing paragraphs as if specifically alleged herein.

82. Section 504 provides, in pertinent part that "no otherwise qualified individual with a disability in the United States… shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a).

83. NY DOH was, at all times relevant to this action, and is currently a recipient of federal financial assistance within the meaning of Section 504.

84. NY DOH provided and provides a "program or activity" where "program or activity" is described as "all operations of a department, agency, special purpose district or other instrumentality of a State or of a local government." 29. U.S. C. § 794(b)(1)(A).

85. A disability is defined as "a physical or mental impairment that substantially limits one or more major life activities of such individual." 29 U.S.C. § 705(9)(B) citing 42 U.S.C. § 12102(1)(A).

86. People with disabilities who seek acute medical care in New York State are qualified individuals under Section 504.

87. NY DOH's Guideline violate Section 594 by authorizing, or failing to forbid, actions that:

h. Exclude from participation in, deny the benefits of, or otherwise subject individuals to discrimination on the basis of disability. 29 U.S.C.§ 794(a); 45 C.F.R. §§ 84.4(a), 84.52(a)(1); 28 C.F.R. § 41.51(a).

i. Deny qualified persons with a disability the opportunity to participate in or benefit from the aid, benefit, or service. 45 C.F.R. § 84.4(b)(1)(i); 28 C.F.R. § 41.51(b)(1)(i).

j. Afford qualified persons with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded to others. 45 C.F.R. §§ 84.4(b)(1)(ii), 84.52(a)(2); 28 C.F.R. § 41.51(b)(1)(ii).

k. Limit individuals with a disability in the enjoyment of rights, privileges, advantages and opportunities enjoyed by others receiving an aid, benefit, or service. 45 C.F.R. §§ 84.4(b)(1)(vii), 84.52(a)(4); 28 C.F.R. § 41.51(b)(1)(vii).

l. Use criteria or methods of administration that have the effect of subjecting qualified persons to discrimination on the basis of disability, or that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of a program or activity with respect to persons with disabilities. 45 C.F.R. §§ 84.4(b)(4) and 84.52(a)(4); 28 C.F.R. § 41.51(b)(3).

88. As a result of NY DOH's acts and omissions, individuals with disabilities seeking acute medical care in New York State have and will continue to be excluded from participation in, denied the benefits of, and subjected to discrimination from the healthcare system adhering to the NY DOH Guidelines.

PRAYER FOR RELIEF

WHEREFORE, DRNY requests relief as set forth below:

1. Issue a declaratory judgment that NY DOH's Ventilator Allocation Guidelines have subjected and continue to subject people with disabilities seeking acute healthcare in New York State to discrimination in violation of Title II of the ADA and Section 504.
2. Direct the NY DOH to issue new Ventilator Allocation Guidelines that do not discriminate against people disabilities seeking acute healthcare in New York State.
3. An award of reasonable attorneys' fees and costs; and
4. Such other further relief as deemed just and proper.

DATE: April 3, 2020
Albany, NY

DISABILITY RIGHTS NEW YORK
Complainant

/s/ Jessica Barlow

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