TA-W1003 (07/2026)

Clear Form

PO Box 189
Albany, NY 12201-0189
Phone No.: (518) 471-4321
Email: accommodations@thruway.ny.gov

AMERICANS WITH DISABILITIES ACT COMPLAINT

Purpose: This form is used to file a complaint based on disabilities in the provision of services, activities, programs or benefits.

INSTRUCTIONS: Please submit this form to the Director of Accessibility, Equity, Diversity and Employee Engagement (AEDEE) at the mailing or email address above.

Section I Complainant Information

Name (Last, First, MI)	Home Phone No.	Email Address
	( ) -	

Mailing Address	City	State	Zip Code
			-

Section II Details of Claim

Location(s) and date(s) of the circumstances giving rise to your complaint?

Are the circumstances of your complaint continuing? ☐ Yes ☐ No

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 documentation, if available.

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

This complaint form was completed by: ☐ AEDEE ☐ Complainant

Signature _____ Date _____