Appendix A: Sections A – F

Application to Request Reasonable Accommodation
of a Disability

Application for reasonable accommodation may be made to the supervisor or the agency's *Designee for Reasonable Accommodation (DRA) Kelley Greene*. If the request is made to the supervisor, the supervisor will forward the request to the DRA. **All confidential information received by Department personnel pertaining to your request shall be handled as such.** All medical information is confidential and maintained separately from personnel records. This form should be returned to your supervisor or the DRA, Kelley Greene at: Accessibility@hcr.ny.gov 641 Lexington Ave., 8th Floor, New York, NY 10022.

Section A
(To be completed by employee and returned to supervisor or *DRA*)

Name	Civil Service Title	Job Title (if different)
Office/Unit	Work Location	Telephone Number(s)
E-mail address:	Preferred method of communication:	

I am requesting the following reasonable accommodation(s):

It is necessary for me to have this accommodation for the following reason(s):

Employee Signature:	Date:

The employee should retain a copy of this form. The original is filed by the *DRA*.

Application to Request Reasonable Accommodation of Disability

Section B

Initial Response to Request for an Accommodation (To be completed by DRA)

We have reviewed your application for an accommodation.

Name of Employee:

☐ Your request has been approved

Comments:

☐ No decision has been made at this time. We will continue to assess your request. The agency's DRA will contact you within the next two weeks.

Comments:	
Signature of DRA	Date
DRA's name:	

The employee should retain a copy of this form. The original is filed by the *DRA*.

Application to Request Reasonable Accommodation
of Disability

Section C

Notification of Need for Additional Information (To be completed by the *DRA* and returned to the employee)

Name of Employee:

We are continuing to assess your request. To make a determination, we need the following information:

☐ **Medical Documentation**

Please inform your doctor of your application for an accommodation and have your doctor send us medical documentation, indicating the limitations that your disability would place on your job performance. We have enclosed a copy of the duty's description for your title and/or a list of the essential functions of your position for the doctor's reference.

Information should be sent by the following date: _____

The requested information should be provided to the agency's Designee for Reasonable Accommodation (DRA), Kelley Greene.

All medical information pertaining to Reasonable Accommodation must be kept confidential by the Agency.

☐ Other

Explain:

☐ We require no additional information from you at this time.

HCR's review process will include an evaluation of all relevant information. This may include an interview with you and/or your supervisor. After completion of the review, you will be informed in writing by the Commissioner of HCR, or the DRA, regarding the HCR's decision.
We anticipate that the decision will be made by (date): _____
If you have any questions, please contact Kelley Greene at (212) 872-0595.

Signature of DRA	Date

The employee should retain a copy of this form. The original is filed by HCR's DRA.

Application to Request Reasonable Accommodation of Disability

Section D

Notification of Agency Determination: (To be completed by the DRA and returned to the employee)

Name of Employee:

Based on the information you provided, HCR is able to provide you with a reasonable accommodation of your disability, as follows:

☐ The accommodation granted is as you requested in your application.

☐ The accommodation granted differs from the accommodation you requested, as follows:

Please discuss any questions regarding implementation of the accommodation with your supervisor. A letter from the Designee for Reasonable Accommodation (*DRA)* confirming this decision will be sent to you within the next week once you accept the accommodation. If you have any questions, please call Kelley Greene at (212) 872-0595. The employee should retain a copy of this form and return the original with his or her signature to be filed by HCR's DRA.

I accept ____/ rejectthe above reasonable accommodation.	
Employee Signature	Date

-or-

Application to Request Reasonable Accommodation
of Disability

Section E
Notification of Agency Denial of Reasonable Accommodation
(To be completed by the DRA and returned to the employee)

Based on the information you provided, HCR is unable to provide you with a

Name of Employee:

Reasonable accommodation of your disability, as you requested on (date) _____.

We are denying your request for the following reason(s):

Signature of DRA	Date

If you have any questions, please call Kelley Greene at (212) 872-0595. The employee should retain a copy of this form. The original will be filed by the DRA.

Remedies relating to Dissatisfaction with Agency's Reasonable Accommodation Determination

A letter from the DRA confirming the decision will be sent to you within the next week after you receive the Notification of Agency Determination. If you are dissatisfied with the determination, the following options are available to you:

1. You may choose to accept this decision and end the process; or
2. You may choose to file an appeal with the Reasonable Accommodation Appeal Review Committee in accordance with procedures established in the "Procedures for Implementing Reasonable Accommodation for Applicants and Employees with Disabilities and Pregnancy- related Conditions in New York State Agencies." To file your appeal, submit the enclosed form, (Section F) "Request to Appeal a Reasonable Accommodation Determination" to the Reasonable Accommodation Appeals Review Committee at **ARC@cs.ny.gov** or by mail at **Department of Civil Service Empire State Plaza Swan Street Building – Core 1 Empire State Plaza, Albany, NY 12239 Attn: ODIM – ARC.**
3. You may choose to file an internal discrimination complaint with the Office of Employee Relations (OER) Anti-Discrimination Investigation Division (ADID) if you believe that the *HCR*'s determination is unlawful.
4. In addition to the options stated above, other alternatives may also be available. These include, but are not limited to:
    - filing a complaint with any compliance agency designated under Sections 503/504 of the Rehabilitation Act of 1973;
    - filing a complaint with the New York State Division of Human Rights;
    - filing a complaint with the Equal Employment Opportunity Commission or any appropriate federal oversight agency under the American with Disabilities Act; and

- filing a private right of action to challenge the alleged discriminatory act, under the New York State Human Rights Law, or any applicable statute.

You may initiate these alternatives after the first denial by HCR of your request for an accommodation. Although these time limitations vary, the time for filing a complaint pursuant to all the alternatives begins to run when HCR first denies your request for an accommodation. However, you should consult with the appropriate anti-discrimination agency as to the time limitations for initiating such an action.

Section F

Request to Appeal a Reasonable Accommodation Determination (this form shall not be modified by accommodating agencies)

This form and all available relevant documentation must be completed by the employee and submitted to the ODIM Reasonable Accommodation Appeals Review Committee at **(ARC@cs.ny.gov) or by mail at Department of Civil Service Empire State Plaza Swan Street Building – Core 1 Empire State Plaza, Albany, NY 12239 Attn: ODIM – ARC.** Inquiries should be directed **to (ARC@cs.ny.gov).**

Name:	Telephone Number:
Mailing Address:	Email Address:
Preferred Method of Communication:	
Agency/Location/Office/Division	Job Title:
Date of Initial Request for Accommodation:	Specific Accommodation Requested:
Date of Agency Determination (Modification or Denial of Reasonable Accommodation Request):	Medical Limitation:
☐ Check here if you have not received a determination from your agency and are not currently engaged in the interactive process regarding your accommodation request:	Have you filed a complaint of discrimination related to this Reasonable Accommodation Request? YES ☐ ☐ NO

Please provide as much of the following information as is available to you to go along with this Request to Appeal:

Reasonable Accommodation Request:

- ☐ Initial Request for Accommodation
- ☐ Agency Confirmation of the Received Request for Accommodation
- ☐ Agency Request for Additional Supporting/Medical Documentation
- ☐ Agency Determination of the Request for Accommodation

Correspondence/written communication with your agency

- Any email or hard copy correspondence with your agency related to the requested accommodation. Do not delete or eliminate any information from emails/email chain.

Medical Documentation

- In addition to medical documentation, please also include any agency requests for additional documentation and/or requests to speak directly with a medical professional.

Job Duties

- Detailed description of job duties and responsibilities

Signature _____ Date _____