

**HCR Employee Application to Request  
Reasonable Accommodation of a Disability**

Application for reasonable accommodation may be made to the supervisor or the Designee for Reasonable Accommodation (DRA), Kelley Greene or your supervisor. If the request is made to the supervisor, the supervisor will forward the request to the DRA. All confidential information received by HCR 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](mailto:Accessibility@hcr.ny.gov) , 641 Lexington Ave., 8<sup>th</sup> Floor New York, NY. 10022 (212) 872-0595.

**(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.

## Section B

### Initial Response to Request for an Accommodation

(To be completed by DRA)

Name of Employee:

We have reviewed your application for an accommodation.

Your request has been approved

Comments:

No decision has been made at this time. We will continue to assess your request.  
The Designee for Reasonable Accommodation (DRA) will contact you within the next two weeks.

Comments:

HCR DRA's Signature

Date

DRA's name:

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

## 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.

A copy of the duties description for your title; or –

A list of the essential functions of your position is attached for the doctor's reference.

Information should be sent by the following date: \_\_\_\_\_

The report should be provided to the DRA, Kelley Greene, at [Accessibility@hcr.ny.gov](mailto:Accessibility@hcr.ny.gov)

**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.

The Agency'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 HCR's DRA regarding the Agency's decision.

We anticipate that the decision will be made by (date): \_\_\_\_\_

If you have any questions, please call Kelley Greene at (212) 872-0595.

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

**Section D**

**Notification of Agency Determination:**

**(To be completed by the DRA and  
returned to the employee)**

Name of Employee:
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Based on the information you provided, the NYSHCR 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:

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Please discuss this with your supervisor. A letter from HCR's 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 the employee's signature to be filed by HCR's DRA.

I accept __/ reject __ the above reasonable accommodation.	
Employee Signature	Date

**-or-**

Based on the information you provided, the NYSHCR is unable to provide you with a Reasonable Accommodation of your disability, as you requested on \_\_\_\_\_ .

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

### **Remedies relating to Dissatisfaction with Agency's Reasonable Accommodation Determination**

A letter from HCR's DRA, Kelley Greene, 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, you now have several options:

1. You may choose to accept this decision and end the process; or
2. You may choose to file an internal discrimination complaint at this time if you feel that the NYSHCR's determination is unlawful.
3. 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 the NYSHCR 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 the NYSHCR 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.