REASONABLE ACCOMMODATION REQUEST FORM

INSTRUCTIONS: Clients must complete Section I and submit this form along with supporting documentation to the Program/Facility Director, or functional equivalent ("Director"). Any Director receiving a completed form with appropriate medical documentation must complete Section II, return a copy to the client, and immediately transmit by facsimile the request and supporting documents to the appropriate Program Administrator, and the Office of Diversity & Equal Opportunity Affairs.

Section I: (This section must be completed by the client.)

Name: ____

Address/Facility/Program: ____

Social Security #: ________________________ Phone: ____________________________

Describe the Accommodation Requested (attach additional sheets and supporting documentation as appropriate).

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Section II: (To be completed by the Director or his/her designee.)

Name/Title: ____

Facility/Program: ____

Address: ____

Phone: _________________________ Date Received: __________________________

Signature: ____

After completing this section, the Director must give a copy of this form to the client and immediately fax the request to the appropriate Program Administrator, Program Analyst and the Office of Diversity & Equal Opportunity Affairs, 33 Beaver Street, New York, New York 10004/Tel. 212-361-7914/ Fax. 212.361.7912/ TTY. 212-361-7915/ eoa@dhs.nyc.gov.

Section III: (To be completed by the Program Administrator or his/her designee.)

Name/Title: ____

Phone: __________________________ Date Received: ____________________________________

Signature: ____

Detailed record of the accommodation review process, including but limited to: a description of medical documentation received; Director/Program Administrator comments; notes regarding consultations with DHS Medical Director and, as needed, Client Advocacy; proposed accommodations; final determination.

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