



THE CITY OF NEW YORK  
DEPARTMENT OF CORRECTION



# DIRECTIVE

<input type="checkbox"/> NEW <input type="checkbox"/> INTERIM <input checked="" type="checkbox"/> REVISED			SUBJECT		
EFFECTIVE DATE <b>3/11/22</b>		*TERMINATION DATE / /		<b>NON-DISCRIMINATION OF INCARCERATED INDIVIDUALS WITH DISABILITIES</b>	
CLASSIFICATION # <b>3802R-B</b>	SUPERSEDES <b>3802R-A</b>	DATED <b>11/30/18</b>	APPROVED FOR WEB POSTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	DISTRIBUTION <b>B</b>	PAGE 1 OF 20 PAGES
RECOMMENDED FOR APPROVAL BY REVIEW BOARD MEMBER  <i>Kenneth Stukes</i> KENNETH STUKES, CHIEF OF DEPARTMENT    SIGNATURE			AUTHORIZED BY THE COMMISSIONER  <i>Louis A. Molina</i> LOUIS A. MOLINA    SIGNATURE		



## I. PURPOSE

Title II (Subtitle A) of the Americans with Disabilities Act (ADA) prohibits public entities, including the New York City Department of Correction, from discriminating against any individual with a disability in its services, programs, activities, and facilities. The New York City Human Rights Law also protects individuals with disabilities from discrimination. This Directive describes the Department's policies and procedures to ensure that incarcerated individuals are not subject to unlawful discrimination on the basis of disability.

This Directive also sets forth guidelines for reasonable accommodations and services, the request and approval process for reasonable accommodations, the identification of incarcerated individual with disabilities in the Department's custody, the role of the Department's Disability Rights Coordinator (DRC) and other staff, and policies concerning other issues that arise relating to incarcerated individual with disabilities.

## II. POLICY

- A. The Department shall not discriminate against any incarcerated individual on the basis of his or her disability or deny an incarcerated individual with a disability from participating in services, programs, or activities based on his or her disability. The Department shall provide reasonable accommodations or make reasonable modifications to existing policies and procedures that are consistent with legitimate penological interests in order to afford incarcerated individuals with disabilities equal access to, and participation in, services, programs, activities, information and facilities. Such modifications may be made both broadly, as policies, procedures and facilities are examined for accessibility, and on a case-by-case basis of the incarcerated individual's request for reasonable accommodations.
- B. The Department shall take appropriate steps to ensure that effective communication is provided for individuals with disabilities (including incarcerated individuals with hearing or vision impairments, and those with intellectual, psychiatric, learning and/or speech disabilities). The obligation to provide effective communication shall also



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- include communications pertaining to ensuring that individuals with disabilities have an equal opportunity to participate in and benefit from all aspects of the agency's safety and security efforts to prevent, detect and respond to sexual abuse and sexual harassment.
- C. Incarcerated individuals with disabilities shall be housed in the most integrated setting appropriate to their needs. They shall not be housed in designated medical areas unless they have been referred to such an area by a health care provider and are receiving medical care and treatment.
  - D. The Department shall educate staff and incarcerated individuals regarding its zero-tolerance policy for discrimination against incarcerated individuals with disabilities, shall provide training on disability sensitivity/awareness issues to optimize interaction and communication with incarcerated individuals with disabilities, and shall provide instructions on assisting incarcerated individuals to access auxiliary aids and services.
  - E. The Department shall ensure that procedures are in place for incarcerated individuals with disabilities to request reasonable accommodations, to make disability-related complaints, and to prohibit unlawful treatment based on disability.

## III. DEFINITIONS

- A. **Assistive Devices** – Devices that assist incarcerated individuals with mobility impairments including, but not limited to, canes, crutches, prosthetic devices, walkers, and wheelchairs.
- B. **Auxiliary Aids and Services** – Devices and services that assist incarcerated individuals with disabilities, including those who are deaf, hard-of-hearing, blind, or who have low vision. These include, but are not limited to, qualified sign language interpreters, text telephones (TTYs), video relay services (if available), hearing aids, closed captioning, readers and scanners, audio recordings, magnification tools, large print materials and specialized computer software.
- C. **Cooperative Dialogue** - The process by which a DOC representative and an incarcerated individual entitled to a reasonable accommodation or who may be entitled to a reasonable accommodation under the law, engage in good faith written or oral dialogue concerning the incarcerated individual's accommodation needs; potential accommodations that may address the incarcerated individual's accommodation needs, including alternatives to a requested accommodation; and the difficulties that such potential accommodations may pose for DOC.

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D. Disability As defined in the Americans with Disabilities Act (42 USC § 12102(2); 28 CFR § 35.104), the term “disability” means:

1. A physical or mental impairment that substantially limits one or more of the major life activities of such individual such as walking, talking, hearing, learning, or one or more major bodily functions such as the immune, circulatory or respiratory system;
2. A record of such an impairment; or
3. Being regarded as having such an impairment.

As defined in the New York City Human Rights Law (Ad. Code § 8-102), the term “disability” means any physical, medical, mental or psychological impairment, or a history or record of such impairment.



- E. Disability-Related Complaint - means any complaint by an incarcerated individual, or by another person on behalf of an incarcerated individual, alleging any conduct that would be prohibited by the ADA or the disability related provisions of the New York City Human Rights Law.
- F. Effective Communication - Communication (written or spoken) with persons with disabilities, including those who are blind, visually impaired, deaf, hard of hearing, or have a speech disability, that is as effective, clear, and understandable as communication with others without a disability.
- G. Qualified Interpreter – An interpreter who, via a video remote interpreting service or an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.
- H. Reasonable Accommodation - Changes to Department policies, practices, or procedures, including, but not limited to, modifications to general incarcerated individuals' policies and procedures, the physical environment, formats for receiving information, or the manner in which tasks are carried out that enable an incarcerated individual with a disability to have equal access to, and participate in, a service, program, activity or use of a facility.

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#### IV. STAFF RESPONSIBILITIES



Department Staff:

- A. Disability Rights Coordinator – The Disability Rights Coordinator (DRC) or designee shall:
1. Ensure that policies, practices, or procedures are in place, publicized, and implemented for the prompt and equitable resolution of requests for accommodations submitted by incarcerated individuals with disabilities and/or disability-related complaints.
  2. Process, investigate, and promptly act upon individual disability-related complaints and/or requests for reasonable accommodations, including monitoring the status of an appeal filed by an incarcerated individual regarding a denial or modification of a request for a reasonable accommodation.
  3. Visit incarcerated individuals with disabilities including those who have requested or been granted reasonable accommodations to ensure the Department's compliance with legal requirements pertaining to incarcerated individuals with disabilities. Visits will be recorded in the facility logbooks and in the DRC's records.
  4. Monitor housing assignments of incarcerated individuals with disabilities and alert the Deputy Commissioner when an assignment appears not to be appropriate for an incarcerated individual because of a disability.
  5. Develop and maintain an inventory of written materials and other resources concerning legal protections for individuals with disabilities, and coordinate the Department's responsibilities to incarcerated individuals, under the ADA and the City Human Rights Law.
  6. Serve as a resource for incarcerated individuals, other Department employees, and representatives of federal, state, and city government agencies who have questions or concerns regarding incarcerated individuals with disabilities, including the Department's obligations or procedures concerning compliance with the ADA and the New York City Human Rights Law.
  7. Maintain a database of incarcerated individuals with disabilities, as reported weekly by all facilities, to keep track of all incarcerated individuals with disabilities in the Department and to ensure that they are provided equal access to services, programs, or activities offered by the Department.
  8. Coordinate action on requests for reasonable accommodations by incarcerated individuals with disabilities and disability-related complaints with appropriate personnel throughout the Department and/or other agencies including:

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- a. Cooperative dialogue with the incarcerated individual.
  - b. Evaluation of the incarcerated individual by qualified experts, as necessary.
  - c. Transfer of the incarcerated individual to an appropriate facility, or relocation within a facility.
  - d. The incarcerated individual's access to appropriate auxiliary aids and services, assistive devices, and other necessary equipment consistent with the professional evaluation of the disability and recommendation provided by the professional.
  - e. Refer disability-related complaints concerning medical issues to Correctional Health Services (CHS).
  - f. Keep records of the provision of assistive devices and any actions taken to address requests for reasonable accommodations or disability-related complaints.
9. Ensure that all Departmental staff who interact with incarcerated individuals with disabilities are provided with adequate and appropriate information and training on issues related to the ADA and the City Human Rights Law, including but not limited to, procedures for addressing disability-related complaints and requests for reasonable accommodations, including auxiliary aids and services, and disability/sensitivity training.
- B. Deputy Warden for Programs – The Deputy Warden for Programs shall:
1. Serve as a liaison between incarcerated individuals in the facility and the DRC or their designee. However, nothing in this section shall prevent an incarcerated individual from contacting the DRC or their designee directly.
  2. Investigate, act upon, and implement any response or remedial action as a result of disability-related complaints and/or requests for reasonable accommodations brought to their attention by the DRC or other staff.
  3. Notify the DRC or their designee in writing within two (2) business days of incarcerated individuals' reasonable accommodation requests or disability-related complaints submitted to the Department, including both written requests and complaints which are subject to review by the DRC, in instances where a request or complaint is addressed informally at the facility level. The DRC shall also be responsible for tracking those requests.

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##### C. Social Service Counselors and/or Grievance Coordinators shall:

1. Inform an incarcerated individual with a disability of available services, including offering assistance with the reasonable accommodation process and completion of forms.
2. Serve as a liaison between the incarcerated individual making a disability-related complaint or requesting a reasonable accommodation; the DRC or designee and the Deputy Warden for Programs or their designee at a facility.
3. Meet and address the questions or concerns of incarcerated individuals with disabilities at the facility level, as identified by the Intake Captain, Deputy Warden for Programs and/or the DRC, or designee.
4. Forward all inquiries relating to disability-related complaints or requests for reasonable accommodation relating to disability, including necessary forms in writing, to the DRC or designee.
5. Communicate with incarcerated individuals and their representatives, using auxiliary aids and services as needed, and follow up on disability-related complaints or reasonable accommodation requests referred by the DRC, including providing incarcerated individuals with status updates on reasonable accommodation requests.



#### V. PRIVACY

Department staff are instructed not to disclose any information concerning an incarcerated individual's disability status to other incarcerated individuals or staff except as necessary to carry out the Department's policy under this Directive. For example, staff may disclose information for the purpose of ensuring that an incarcerated individual with a disability receives the reasonable accommodations that they need, and to comply with the reporting requirements of this directive.

#### VI. PROCEDURES

##### A. Requests for Reasonable Accommodation made at Intake:



1. Court Detention Facility/Direct Admission to Department Facility
  - a. When an incarcerated individual is received at a Department court detention facility or as a direct admission to a Department facility, the staff

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member processing the incarcerated individual for admission shall, in the course of filling out the Arraignment and Classification Risk Screening Form (ARC 239M), inquire whether the incarcerated individual has a disability, and whether the incarcerated individual is requesting a reasonable accommodation; and shall note the incarcerated individual's response on the Form. If the response to either or both questions is in the affirmative, and/or it is apparent that the incarcerated individual has a disability (for example, the incarcerated individual uses a wheelchair) the staff member shall notify the DRC or designee and the Deputy Warden for Programs in writing within two (2) business days.

- b. Upon intake, the Department may temporarily take an incarcerated individual's cane or other assistive device that presents a security risk, such as those that can be used as a weapon or to hide contraband, and replace it with an equally effective assistive device that does not pose a security risk, as long as CHS promptly evaluates the incarcerated individual to ensure that the alternative device meets the incarcerated individual's needs. For example, CHS may give an incarcerated individual a wooden cane to replace a metal cane provided that CHS determined that would meet the incarcerated individual's needs.
2. Notice to Captains, Social Services Counselor/Grievance Coordinator and Disability Rights Coordinator
    - a. When an incarcerated individual known to have a disability is admitted to a Departmental facility, or transferred from one facility to another, the Receiving Room/Intake Area Captain, or designee, shall immediately notify the facility Social Services Counselor/Grievance Coordinator, the Disability Rights Coordinator (DRC) or designee, in writing. The notification to all interested parties shall include the incarcerated individual's name, NYSID number, Book & Case number, the nature of the incarcerated individual's disability, if known to the Department, and any request for accommodation made by that incarcerated individual at Intake.
    - b. Should incarcerated individuals known to the Department to have disabilities be admitted to the facility outside of regular business hours, the Intake Area Captain shall forward Form 3802D (Notification to Counseling Services Unit) to the Counseling Services Unit, the Deputy Warden for Programs or designee, and the DRC or designee, containing each incarcerated individual's name, NYSID number, Book & Case number, nature of disability, if known to the Department, requested accommodation and housing location. This form must be prepared and forwarded prior to the completion of the Captain's tour of duty.

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- c. The Department shall receive notice from CHS, after CHS has conducted an intake assessment, of any assistive device that an incarcerated individual may need because of a disability, and any recommendation for special housing that is appropriate in light of an incarcerated individual's disability.
3. Intake Visit by Social Services Counselor and/or Grievance Coordinator and/or Disability Rights Coordinator

Upon being notified of the admission of an incarcerated individual with a disability, a Social Services Counselor/Grievance Coordinator and the DRC, or designee, shall confer and make arrangements to meet with the incarcerated individual as soon as practicable to inform the incarcerated individual of all services and programs available to incarcerated individuals with disabilities.

### B. Requests for Accommodation or Disability-Related Complaint made Post Intake.



1. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may request a reasonable accommodation or make a disability-related complaint by any of the following methods:
  - a. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may complete the Incarcerated Individual Reasonable Accommodation Request (IIRAR) form (Form #3802A, Attachment A) and submit the form with applicable supporting documentation, if necessary, to the Social Services Counselor, Grievance Coordinator, and/or the Disability Rights Coordinator or designee. IIRAR forms may be obtained from multiple areas including intake areas, housing areas, the Counseling Services Unit, Medical Clinics and Law Libraries.
  - b. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may call the DRC on the dedicated phone line.
  - c. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may complete a request via the Service Desk with a Grievance Coordinator.
  - d. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may call 311.
  - e. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may mail a written request to the DRC or designee.



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- f. An incarcerated individual, or any other individual on an incarcerated individual's behalf, may make a request to CHS.
- C. Procedures for Documenting Requests for Reasonable Accommodations and Disability-Related Complaints.
1. In non-emergency situations, when seeking an accommodation, an incarcerated individual (or a person acting on the incarcerated individual's behalf), will be asked to complete the Incarcerated Individual Reasonable Accommodation Request form (Form 3802A).
  2. When a request for an accommodation is deemed to be an emergency or time sensitive, the request may be made orally or in writing, and an incarcerated individual (or a person acting on the incarcerated individual's behalf), will be asked to complete the Incarcerated Individual Reasonable Accommodation Request form (Form 3802A) later.
  3. If medical information is needed to respond to the request or complaint, the incarcerated individual shall also be provided with a HIPAA authorization form, with an explanation that: (1) the incarcerated individual's decision to sign, or not sign the form, will not affect any medical examination to be conducted; access to treatment, or any recommendation for a reasonable accommodation; and (2) the incarcerated individual's decision to sign the form would enable the Department to discuss the incarcerated individual's need with medical providers and to report certain information to oversight authorities.
  4. If the request or complaint is received by the Social Service Counselor or Grievance Coordinator, the completed forms will be forwarded to the DRC or designee immediately upon completion. The communication to the DRC or designee shall include the name of the facility, the incarcerated individual's name, NYSID number, Book & Case number, housing area, the nature of the incarcerated individual's disability, if known to the Department, and any request for accommodation or disability-related complaint made by said incarcerated individual.
  5. If the contact with the DRC or designee regarding an incarcerated individual with a disability is made by phone, a written memo that includes the above information shall be prepared by the DRC or designee. Records of all such written communication shall be maintained in the Counseling Services Unit and/or Grievance Unit and by the DRC or designee.
  6. The Social Services Counselor, Grievance Coordinator or other available staff shall assist the incarcerated individual in completing the IIRAR form (Form #3802A) and the HIPAA form whenever necessary, including, but not limited to,

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when assistance is necessary because of the incarcerated individual's disability. The staff member who first receives the IIRAR form will forward it to the DRC or designee, who will then forward an acknowledgement to the incarcerated individual by signing and dating the form in the space provided and provide a copy to the incarcerated individual.



7. Upon receipt of a reasonable accommodation request or disability-related complaint, the DRC or designee shall enter the request or complaint into a request tracking database such as Service Desk and/or any other accepted tracking mechanism.
  8. The DRC or designee shall provide the incarcerated individual with a written acknowledgment of receipt of the accommodation request (Form 3802 B) within five (5) business days of receiving the request. The written acknowledgement may be delivered by mail or during an in-person visit. The acknowledgment may include a determination to the extent one is made, notice that further information is necessary to address the request, and/or a statement that the request will be processed as soon as possible. Written acknowledgements shall also be sent to individuals who have submitted requests on behalf of an incarcerated individual pursuant to this Directive.
- D. Reviewing and Making Determinations on Accommodation Requests and Disability-Related Complaints.
1. The DRC or designee shall be responsible for reviewing and making determinations on all requests for accommodations and disability-related complaints made to the Department. The DRC or designee shall consult as needed with CHS, the Deputy Warden for Programs, or the Warden.
  2. The DRC or designee shall engage in a cooperative dialog with the incarcerated individual about the request for reasonable accommodation. This shall occur within five (5) business days of receipt of the request for accommodation or disability-related complaint, absent exceptional circumstances that shall be documented. The DRC or designee shall consider the incarcerated individual's preference as to the type of accommodation to be provided; and request additional information if what is being sought is not clear or is needed to evaluate and respond to the request or complaint.
  3. The Department shall not unreasonably deny an accommodation request submitted by, or on behalf of, an incarcerated individual with a disability. The Department shall provide a reasonable accommodation for an incarcerated individual who needs it unless doing so would result in a fundamental alteration

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to the nature of a service, program, or activity or compromise the safety or security of incarcerated individuals or the facility. While the Department shall give primary consideration to the specific accommodation or auxiliary aid/service requested by the incarcerated individual, the Department may choose to provide an alternative effective accommodation or auxiliary aid/service. To the extent the Department determines that the requested accommodation would fundamentally alter the nature of a service, program, or activity, or compromise the safety or security of incarcerated individuals or the facility, the Department shall seek to provide an alternative accommodation that will ensure that the incarcerated individual has equal access to programs, activities, and services.

4. The Department shall allow an incarcerated individual to be seen by CHS for evaluation of the need for a reasonable accommodation. CHS shall notify the DRC, or designee, of its recommendation. The Department shall follow the recommendation of CHS as to an accommodation to be provided, except where the accommodation would fundamentally alter the nature of a service, program, or activity, in which case the Department shall seek to provide a reasonable accommodation that does not present such an alteration. If the Department does not follow a CHS recommendation, it shall notify CHS.
5. The DRC or designee shall provide the incarcerated individual with a written notification of the Determination of Request for Reasonable Accommodation on Form 3802C. Requests shall be either granted, granted with a modification, or denied. If the accommodation requested is denied, or an accommodation different from the one requested is approved, the form shall provide a detailed explanation, and shall inform the incarcerated individual of their right to appeal the decision to the Deputy Commissioner for Health Affairs by completing Form 3802E, "Incarcerated Individual Appeal of Reasonable Accommodation Determination" (Attachment E), within ten (10) days of receipt of the written determination. Form 3802E shall be made available in all intake areas, medical clinics, law libraries, and counseling services units. If the request was submitted by an individual on behalf of the incarcerated individual, DOC shall also promptly advise that individual in writing of the determination, the basis for the determination, and the right to appeal provided that the individual submits an appropriate release executed by the incarcerated individual authorizing disclosure of such information.
6. The DRC shall communicate all decisions made pursuant to this section, in writing to the Social Services Counselor and/or Grievance Coordinator, and the Deputy Warden for Programs, and record the determination in the Department's tracking system.

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7. Each disability-related complaint or request for reasonable accommodation must be granted or denied within ten (10) business days of submission, unless there are exceptional circumstances such as hospitalization of the incarcerated individual, time needed to procure assistive devices, or a trial that make reaching a determination within such time impracticable, in which case the DRC or his/her designee shall document these exceptional circumstances, inform the incarcerated individual within ten (10) business days of the status of evaluation of the request, and make a determination with respect to the complaint or request as soon as practicable.
- E. Implementing a Reasonable Accommodation That Has Been Approved by the Department.
1. The Deputy Warden for Programs shall notify the Warden in writing when an accommodation request made to the Department has been approved and shall ensure that an approved reasonable accommodation is implemented.
  2. An approved accommodation shall be implemented as soon as practicable.
  3. The DRC, or designee, shall verify that reasonable accommodations approved by the Department have been implemented. If an approved accommodation has not been implemented within ten (10) days of the approval, the DRC shall provide status updates to the incarcerated individual every ten (10) business days thereafter until the approved accommodation has been implemented. The DRC, or designee, shall advise the Deputy Commissioner for Health Affairs of any failure to timely provide an approved accommodation.
  4. When an incarcerated individual who is receiving an accommodation for a disability is transferred, notice shall be given to the Receiving Captain as described in Part A. 2. a. above.
  5. An incarcerated individual whose assistive device needs maintenance, repair or replacement may bring the matter to the attention of the DRC, or designee, a Social Service Counselor or a Grievance Coordinator.
- F. Providing Reasonable Accommodations or Assistive Devices That Have Been Approved or Recommended by CHS.
1. CHS may identify an incarcerated individual's need for an accommodation or an assistive device at intake, because of a referral made by the Department, or during the course of other interactions with the incarcerated individual. CHS provides assistive devices directly to the incarcerated individual. CHS maintains

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records as to when incarcerated individuals may need to be re-examined to determine whether their need for a reasonable accommodation or an assistive device is continuing.



2. CHS shall notify the Department of the incarcerated individual's need for a reasonable accommodation or an assistive device by sending a notice to the Deputy Warden for Programs and the DRC that includes the date of medical appointment, information regarding whether any assistive devices were provided to the incarcerated individual, whether any other reasonable accommodation for the incarcerated individual's disability (for example, special housing) is recommended, and the length of time for the accommodation.
  3. The Department shall make the final determination as to an incarcerated individual's housing assignment. The Department shall consult with CHS prior to making an assignment different from the one CHS recommended.
- G. Review of CHS Medical Findings Concerning a Reasonable Accommodation Request or an Assistive Device.
1. When CHS does not approve an assistive device an incarcerated individual requested, and/or when the incarcerated individual has any complaint relating to a reasonable accommodation provided or not provided by CHS or the Department, the incarcerated individual, or an individual acting on the incarcerated individual's behalf, may notify the DRC or their designee of the denial by CHS, using any of the methods described in Section VI. B.
  2. The DRC or designee may refer the incarcerated individual to CHS or any other expert, for a second opinion about the need for the device.
  3. The incarcerated individual may be asked to provide the Department with a HIPAA authorization to enable the Department to review CHS documentation and discuss the incarcerated individual's request with CHS personnel or other experts.
  4. The DRC or designee shall notify the incarcerated individual in writing about the resolution of the request. If the request was submitted by an individual on behalf of the incarcerated individual, DOC also shall promptly advise that individual in writing of the determination, the basis for the determination, and the right to appeal, provided that the individual submits an appropriate release executed by the incarcerated individual authorizing disclosure of such information.

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### H. Questions about Continuing Need for, or Improper Use of, a Reasonable Accommodation or Assistive Device

1. If the Department believes that an incarcerated individual has an assistive device or is receiving a reasonable accommodation that is not needed, the Department may refer the incarcerated individual to CHS for a follow-up examination to determine if the device or accommodation is still medically necessary. The Department shall notify CHS of the reason for the referral and inform the DRC or designee.
  - a. If CHS confirms the need for the assistive device or accommodation, the Department shall allow the incarcerated individual to continue to have it.
  - b. If CHS does not confirm the need for the assistive device, the Department may confiscate it. If CHS does not confirm the need for the accommodation, the Department may terminate it.
  - c. If the incarcerated individual refuses to be examined and the period of time for which CHS had approved use of the device or the accommodation has expired, DOC may confiscate the assistive device or suspend the accommodation until such time as the incarcerated individual agrees to be re-examined.
  - d. The DRC shall provide the incarcerated individual with a written explanation of the reason for the confiscation of a device or the termination or suspension of an accommodation and notice of the right to appeal.
2. If the Department has reason to believe that an incarcerated individual is using an assistive device or medical equipment in a manner that raises security concerns or poses a threat to the safety of staff, incarcerated individuals, or others, the Department may confiscate the device or equipment and will immediately refer the incarcerated individual to CHS for an examination to assess whether there is a continuing need for the assistive device or medical equipment. DOC staff shall notify and obtain confirmation from a supervisor that confiscating the device or equipment serves a legitimate security purpose. The supervisory approval shall be obtained at the time of the confiscation if a supervisor is immediately available or within 24 hours of the confiscation if a supervisor is not immediately available. If an incarcerated individual's device or equipment is confiscated, the facility's Deputy Warden for Security, medical staff, and the DRC shall be promptly advised in writing that the device or equipment has been confiscated by the supervisor on Form 3802G "Confiscation of Assistive Devices." Medical staff shall then promptly re-evaluate the incarcerated individual's medical status and need for the device or medical equipment.

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## VI. PROCEDURES (Cont.)

- a. If CHS confirms the need for the device or equipment, the Department shall return the device or equipment to the incarcerated individual, unless the facility's Warden or designee determines that this would pose a security or safety risk and documents the basis for that determination, in which case an appropriate substitute device or equipment shall be provided to the incarcerated individual.
    - b. If CHS does not confirm the need for the device, the Department does not need to return it to the incarcerated individual and an infraction may be generated pursuant to the conduct observed. The Department shall inform the DRC or designee if a device is confiscated.
    - c. The DRC shall provide the incarcerated individual with a written explanation of the reason for the confiscation or any substitute and notice of the right to appeal.
  3. An individual whose device has been confiscated or substituted shall have the right to appeal within ten (10) days by completing Form 3802E, "Incarcerated Individuals Appeal of Reasonable Accommodation Determination" (Attachment E).
- f. Appeal
1. An individual may appeal a decision pertaining to a disability-related complaint or a request for reasonable accommodation to the Deputy Commissioner for Health Affairs by completing Form 3802E, "Incarcerated Individual Appeal of Reasonable Accommodation Determination" (Attachment E) within ten (10) days of receipt of the written determination from the DRC or designee.
  2. The Deputy Commissioner of Health Affairs, or designee, shall review the appeal and issue a written decision. They shall review all documents relating to the appeal including, but not limited to, documents provided by the incarcerated individual in support of the requested accommodation and documents relied upon by the DRC or designee in making the determination, including all relevant medical records that the incarcerated individual has authorized CHS or other relevant medical provider to disclose by signing a HIPAA authorization.
  3. A written decision shall be provided by the Deputy Commissioner of Health Affairs using form 3802F, "Appeal Determination for Incarcerated Individual Reasonable Accommodation Request (Attachment F), within 14 days of receipt of the appeal. If extenuating circumstances prevent compliance with this time period, a determination shall be made as soon as practicable. The Deputy Commissioner of Health Affairs, or designee, shall ensure that their

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## VI. PROCEDURES (Cont.)

determination regarding the appeal is delivered to the incarcerated individual as soon as possible after its issuance.



## VII. RECORD KEEPING

The DRC shall keep a weekly log of incarcerated individuals with disabilities in the Department's custody developed from weekly reports received from CHS at each facility. Information tracked in the log includes the incarcerated individual's name, NYSID number, Book & Case number, admission date, facility, housing area, date of birth, and category of disability. The categories identify sensory disabilities and assistive devices as follows: visually impaired, blind, hard of hearing, deaf, deaf-mute, use of a prosthesis, walker, crutches, cane, and part-time or full-time wheelchair.

## VIII. ACCOMMODATIONS AND AUXILIARY AIDS

- A. Auxiliary aids and services shall be available for incarcerated individuals with disabilities of various types. They include, but are not limited to, the following:
1. Hearing aids
  2. Qualified Sign language interpreters
  3. Closed captioning
  4. Telephonic communication devices including Text Telephones (TTYs/TTDs) and Video Relay Services, to the extent available
  5. Audio books on tape
  6. Braille newspapers and/or magazines
  7. Perkins Braille
  8. Document/book scanner/reader
  9. Computer software
  10. Large print materials
  11. Magnifiers



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### VIII. ACCOMMODATIONS AND AUXILIARY AIDS (Cont.)

12. Mobility assistive devices
13. Accessible transportation



### IX. NOTIFICATION / COMMUNICATION

#### A. PUBLICIZING INCARCERATED INDIVIDUAL PROCEDURES

1. A poster, in multiple languages per New York City Local Law 30, notifying incarcerated individuals of the name, address and phone number of the Disability Rights Coordinator, the Social Services Counselor and/or Grievance Coordinator assigned to each facility, and an explanation of the rights of incarcerated individuals with disabilities to request a reasonable accommodation or file a disability-related complaint shall be conspicuously posted in applicable areas of all facilities including, but not limited to, intake areas, law libraries, educational areas, clinics and social service offices.
2. Notices and procedures shall be published in the Incarcerated Individual Handbook that is provided to incarcerated individuals at Intake, including information describing their rights under the ADA; how to submit a request for reasonable accommodation or disability-related complaint, the name and contact information for the DRC, and the resources available for incarcerated individuals, with visual, hearing, mobility, or other impairments. DOC shall provide such materials in large print and in Braille for incarcerated individuals with visual impairments.



#### B. ENSURING EFFECTIVE COMMUNICATION

1. The Department shall provide materials in alternate formats to ensure proper notification to incarcerated individuals with vision impairments.
2. The following non-exhaustive list provides examples of services, programs and/or activities where the Department must provide appropriate auxiliary aids and services, including qualified sign language interpreters, to ensure effective communication with incarcerated individuals who are deaf, hard of hearing, or who have a speech disability.

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## IX. NOTIFICATION / COMMUNICATION (Cont.)

- a. Critical communication, complex information, lengthy exchanges, or anything involving complaints of assault, sexual abuse or harassment;
- b. Intake;
- c. Orientation;
- d. Medical care and health programs such as physicals and medical screenings and treatment, dental, visual, and/or mental health examinations or treatment, and drug and alcohol recovery services;
- e. Counseling or psychological services;
- f. Educational, vocational, and entertainment programming;
- g. Due process hearings, including disciplinary hearings, and hearings in which the incarcerated individual is a witness;
- h. Classification review interviews;
- i. Grievance interviews or processes;
- j. Religious services;
- k. Non-criminal investigations;
- l. Pre-release instructions / Discharge planning;
- m. Trial preparations;
- n. Incarcerated individual reasonable accommodation process;
- o. Emergency preparedness practice;
- p. Employment;
- q. Recreational programs.

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## X. REFERENCES



- A. Operations Order #28/89, Identification of Hearing Impaired/Deaf Mute Inmate, dated 6/19/89 (as amended).
- B. Directive 5011R-A, Elimination of Sexual Abuse and Sexual Harassment dated 5/31/19 (as amended).
- C. Operations Order 43/88, Bi/Multi-Lingual and/or Sign Language Proficient Staff, dated 6/22/88.
- D. Title II, subtitle A of the Americans with Disabilities Act; Title II, (42 U.S.C. 12131); 23 CFR Part 35.

## XI. ATTACHMENTS

- A. Form 3802A, "Incarcerated Individuals Reasonable Accommodation Request (IRAR)"
- B. Form 3802B, "Acknowledgement of Request for Reasonable Accommodation"
- C. Form 3802C, "Determination of Request for Reasonable Accommodation"
- D. Form 3802D, "Notification to Counseling Services Unit"
- E. Form 3802E, "Appeal of Reasonable Accommodation Determination"
- F. Form 3802F, "Appeal Determination for Incarcerated Individual Reasonable Accommodation Request"
- G. Form 3802G, "Confiscation of Assistive Devices"
- H. Form ARC 239M, "Arrestment and Classification Risk Screening Form" dated 11/29/18.
- I. Health Insurance Portability and Accountability Act (HIPAA) Form

## XII. SUPERSEDES

- A. Directive 3802R-A, Reasonable Accommodation for Inmates with Disabilities, dated 11/30/18.
- B. Any other Directive, Operations Order, Teletype, Memorandum, etc., that may be in conflict with the policies and procedures outlined herein.

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### XIII. SPECIAL INSTRUCTIONS

- A. Within ten (10) days of the effective date of this order Commanding Officers of Facilities and Divisions shall each promulgate a Command Level Order to ensure strict compliance with the provisions outlined herein.
- B. Copies of all Command Level Orders shall be forwarded to the office of the respective Bureau/Assistant Chiefs.
- C. Commanding Officers of Facilities and Divisions shall ensure strict compliance with the provisions of this Directive.



CORRECTION DEPARTMENT  
CITY OF NEW YORK



INCARCERATED INDIVIDUAL'S REASONABLE  
ACCOMMODATION REQUEST (IIRAR)

Form: 3802A  
Eff. :3/11/22  
Ref. : Dir. #3802R-B

I request reasonable accommodation due to my impairment. I understand that this is only a request, which will begin the inquiry into whether or not I am entitled to receive a reasonable accommodation. I also understand that my housing will not be immediately affected while my request is under consideration. I will be within my rights to file a grievance through the Incarcerated Individual Grievance Program should I not agree with the determination made regarding this request for reasonable accommodation.

**Note:** Appropriate Department of Correction staff may assist an individual in completing this form.

Incarcerated Individual's Last Name:	Incarcerated Individual's First Name:	Date:
NYSID #:	Book & Case #:	Facility/Housing:

I am/have \_\_\_\_\_  
(State Impairment)

I am unable to \_\_\_\_\_  
(Describe Limitation or Disability)

Accommodation Requested:  
\_\_\_\_\_  
\_\_\_\_\_

A request for an accommodation may be denied if the Department of Correction (DOC) cannot adequately evaluate the request without being provided limited medical information relevant to the accommodation you may be seeking. Your medical information is private and cannot be revealed to DOC without your permission. Do you wish to provide a waiver that allows DOC to obtain medical information from Correctional Health Services or any other medical personnel, private physician or clinic, for the limited purpose of evaluating your accommodation request? You may revoke you waiver at any time by providing DOC written notice of the revocation.

☐ I **do** wish to give DOC access to my medical information for the limited purpose of having DOC evaluate my request for a reasonable accommodation.

Incarcerated Individual's Signature: \_\_\_\_\_ Date:\_\_\_\_\_

☐ I **do not** wish to allow DOC access to my medical records to evaluate my accommodation request. I understand that if DOC determines that my request cannot be properly evaluated without access to my medical information, my request for a reasonable accommodation may be denied for this reason.

Incarcerated Individual's Signature: \_\_\_\_\_ Date:\_\_\_\_\_



Staff Accepting/Assisting with Completion of this Application

Staff Name (Print)	Rank/Title	Shield/ID #	Staff Signature
--------------------	------------	-------------	-----------------

Counseling Services Unit must forward this form to both the D.R.C.  
and facility Deputy Warden for Programs for a determination.

Copies to: Incarcerated Individual; Incarcerated Individual's file; Counseling Services Unit; Deputy Warden for Programs; Disability Rights Coordinator



	CORRECTION DEPARTMENT CITY OF NEW YORK			
	DETERMINATION OF REQUEST FOR REASONABLE ACCOMMODATION		Form: 3802C Eff. : 3/11/22 Ref. : Dir. #3802R-B	
Incarcerated Individual's Last Name:		Incarcerated Individual's First Name:		Date:
NYSID #:	Book & Case #:	Facility:	Housing Area:	
If Form A is not complete, the incarcerated individual must complete the information below:				
Information to be added to Form A:				
Incarcerated Individual's Signature:_____ Date:_____				
Disability Rights Coordinator's Determination (DRC)				
<div><input type="checkbox"/> Approved</div> <div><input type="checkbox"/> Denied</div> <div><input type="checkbox"/> Modified</div> <div>_____</div> <div>Initials</div> <div>_____</div> <div>Date</div>				
Specific accommodation provided:				
Explanation of modification or denial (if applicable):				
Explanation of delay, if any:				
DRC's Signature: _____ Date:_____				
Incarcerated Individual's Signature: _____ Date:_____				
Served to Incarcerated Individual by:				
<div>_____</div> <div>Staff Name (Print)</div> <div>_____</div> <div>Rank/Title</div> <div>_____</div> <div>Shield/ID #</div> <div>_____</div> <div>Staff Signature</div> <div>_____</div> <div>Date</div>				
Copies to: Incarcerated Individual; Incarcerated Individual's file; Counseling Services Unit; Deputy Warden for Programs; Disability Rights Coordinator				



**CORRECTION DEPARTMENT  
CITY OF NEW YORK  
NOTIFICATION TO COUNSELING  
SERVICES UNIT**



Form: 3802D  
Eff. : 3/11/22  
Ref. : Dir. #3802R-B

Should an incarcerated individual with a disability be admitted to the facility during hours when the Counseling Services Unit is closed, the Intake Captain shall forward the below list to the Counseling Services Unit and the Deputy Warden for Programs or designee, containing each incarcerated individual's name, NYSID number, Book & Case number, housing location, nature of disability and accommodation requested. This list must be prepared and forwarded prior to the completion of the Captain's tour of duty.

To: Counseling Services Unit \_\_\_\_\_ Facility \_\_\_\_\_

From: \_\_\_\_\_  
Name Rank Shield #



Date: \_\_\_\_\_



Name of Individual	NYSID #	Book & Case #	Housing Location	Disability	Accommodation Requested

Signature: \_\_\_\_\_

Copies to: Correction Counselor's Office and Deputy Warden for Programs.



	CORRECTION DEPARTMENT CITY OF NEW YORK			
	INCARCERATED INDIVIDUAL'S APPEAL OF REASONABLE ACCOMMODATION DETERMINATION	Form: 3802E Eff. : 3/11/22 Ref. : Dir. #3802R-B		
Incarcerated Individual's Last Name:		Incarcerated Individual's First Name:	Date:	
NYSID #:		Book & Case #:	Facility/Housing:	
Accommodation Request:				
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>				
Date of Request:		Date of Determination:		
Determination:				
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>				
Date of Appeal:				
Reason for Appeal:				
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>				
Individual's Signature: _____ Date: _____				
Staff Name (Print)	Rank/Title	Shield/ID #	Staff Signature	Date
Copies to: Incarcerated Individual; Incarcerated Individual's file; Counseling Services Unit; Deputy Warden for Programs; Disability Rights Coordinator for Incarcerated Individual				

	CORRECTION DEPARTMENT CITY OF NEW YORK			
	APPEAL DETERMINATION FOR INCARCERATED INDIVIDUAL'S REASONABLE ACCOMMODATION REQUEST			
Form: 3802F Eff. : 3/11/22 Ref. : Dir. #3802R-B				
Incarcerated Individual's Last Name:		Incarcerated Individual's First Name:		
Date:				
NYSID #:		Book & Case #:		
Facility/Housing:				
Request:		Request date:		
Appeal Request:				
Individual's Signature: _____Date: _____				
Determination of Deputy Commissioner/ Health Affairs:				
<div><input type="checkbox"/> Approved</div> <div><input type="checkbox"/> Denied</div> <div><input type="checkbox"/> Modified</div>				
Specific accommodation provided:				
Signature of D/C Health Affairs: _____Date: _____				
Served upon Incarcerated Individual by:				
Staff Name (Print)	Rank/Title	Shield/ID #	Staff Signature	Date
Copies to: Incarcerated Individual; Incarcerated Individual's file; Counseling Services Unit; Deputy Warden for Programs; Disability Rights Coordinator				



**CORRECTION DEPARTMENT  
CITY OF NEW YORK**



**CONFISCATION OF ASSISTIVE DEVICES**

Form: 3802G  
Eff. :3/11/22  
Ref. : Dir. #3802R-B

Supervisors shall complete this form any time an assistive device is confiscated from an incarcerated individual who has a current medical authorization, including those with a disability.

Incarcerated Individual's Last Name:	Incarcerated Individual's First Name:	Date:
--------------------------------------	---------------------------------------	-------

NYSID #:	Book & Case #:	Facility:	Housing Area:
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Assistive Device:

Date Assistive Device Confiscated: \_\_\_\_\_

Reason for Confiscation:

Staff Member who Confiscated Assistive Device:

Last Name:	First Name:	Shield #:
------------	-------------	-----------

Was individual referred to medical provider for re-evaluation? ☐ No ☐ Yes



If no, give reason:



\_\_\_\_\_

Supervisor's Last Name:	Supervisor's First Name:	Supervisor's Shield #:
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Signature of Supervisor	Date
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Copies to: Incarcerated Individual; Incarcerated Individual's file; Counseling Services Unit; Deputy Warden for Programs; Deputy Warden for Security; Disability Rights Coordinator

		CORRECTION DEPARTMENT CITY OF NEW YORK				Page 1 of 2 Pages		Form: ARC 239M Rev. : 11/29/18 Ref. : Dir. #4100R-D					
ARRAIGNMENT AND CLASSIFICATION RISK SCREENING FORM													
A	Inmate's Last Name:				First Name:				M.I.:		Book & Case #:		
	N.Y.S.I.D. #:				I.C.E.. #:		Green Card (If yes, indicate #): Yes <input type="checkbox"/> No <input type="checkbox"/>			CMC: Yes <input type="checkbox"/> No <input type="checkbox"/> CMC #: _____			
	Commitment Received From Court: HRS				NYCDOC physical custody date/time: HRS				Destination Facility:				
	ALIASES:	Last Name			First Name			Separation: Yes <input type="checkbox"/> No <input type="checkbox"/>					
						OSIU #:							
						Red ID: Yes <input type="checkbox"/> No <input type="checkbox"/>							
B	MEDICAL TRIAGE (please select one)                      NORMAL <input type="checkbox"/> EXPEDITED <input type="checkbox"/>												
	Do you have immediate medical needs? (if yes, specify) Yes <input type="checkbox"/> No <input type="checkbox"/> _____						Does Securing Order/Commitment Papers indicate medical/mental health attention requested?      Yes <input type="checkbox"/> No <input type="checkbox"/>						
	Do you have any of the following symptoms?:      Fever - Yes <input type="checkbox"/> No <input type="checkbox"/> Cough - Yes <input type="checkbox"/> No <input type="checkbox"/> Sore Throat - Yes <input type="checkbox"/> No <input type="checkbox"/>												
	If "Yes" to any of the above symptoms, refer the inmate directly to medical services												
	Physical condition as stated by inmate:						Officer's observation, include any obvious indication of immediate medical needs or any display of extreme nervousness or depression, etc.:						
	Look for signs of the following (Check when applicable):												
	<input type="checkbox"/> Dilated Pupils			<input type="checkbox"/> Tattoos			<input type="checkbox"/> Signs of trauma (severe bruises or blood on clothing)						
	<input type="checkbox"/> Needle Tracks			<input type="checkbox"/> Puncture Marks			<input type="checkbox"/> Body Deformities (Missing Limbs)						
	<input type="checkbox"/> Staggering			<input type="checkbox"/> Scars (from attempted suicides)			<input type="checkbox"/> Other (Specify) _____						
	Are you disabled? (if Yes, specify) Yes <input type="checkbox"/> No <input type="checkbox"/> _____				Are you requesting a reasonable accommodation? (If Yes, specify) Yes <input type="checkbox"/> No <input type="checkbox"/> _____								
DESCRIPTION OF CLOTHING (INCLUDING MULTIPLE ITEMS)										FINGERPRINTS - LEFT INDEX FINGER	DISCHARGE	ADMISSION	
ITEMS	YES	NO	COLOR	REMARKS	ITEMS	YES	NO	COLOR	REMARKS				
PANTS					COAT/JACKET								
SHIRT/BLOUSE					SHOESTRINGS								
DRESS/SKIRT					HAT								
BELT					SCARF								
SHOES					GLOVES								
SNEAKERS					FACIAL JEWELRY								
Surrendering Officer (print name): signature: _____				Surrendering Officer Signature: _____			Rank: _____		Shield #: _____		Surrendering Agency: _____		
Inmate signature upon admission: _____										Date: _____			
C	Inmate's street address:						Apt. #:			Date of Birth:			
	City:			State:		Zip Code:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/>			
	Race: American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> _____												
	Complexion: Light <input type="checkbox"/> Medium <input type="checkbox"/> Dark <input type="checkbox"/>			Nativity: _____			U.S. Citizen: Yes <input type="checkbox"/> No <input type="checkbox"/>			Height: _____		Weight: _____	
	Religion:	Marital Status:	Drug Abuser? (If Yes, specify): Yes <input type="checkbox"/> No <input type="checkbox"/> _____				Alcohol Abuser: Yes <input type="checkbox"/> No <input type="checkbox"/>		Detox: Yes <input type="checkbox"/> No <input type="checkbox"/>		Shoe Size: _____		
											Eye color: _____		
											Hair color: _____		
	Arrest date:		Arrest Number: _____									Arraignment Date: _____	
	CLOSEST PERSON TO CONTACT IN CASE OF EMERGENCY												
	Last Name:				First Name:				Phone number:			Relationship:	
Street Address:				Apt. #:		City:			State:		Zip code:		
D	English speaking: (If No, what language) Yes <input type="checkbox"/> No <input type="checkbox"/> _____				Level of Education: _____				Social Security #: _____				
	Occupational skills: (If Yes, specify) Yes <input type="checkbox"/> No <input type="checkbox"/> _____				Served in the military: (If Yes, indicate branch, unit and special skills) Yes <input type="checkbox"/> No <input type="checkbox"/> _____								
E	Is this the first time you have been held in jail or custody? Yes <input type="checkbox"/> No <input type="checkbox"/> Conflict <input type="checkbox"/>						Do you know of any reason why you may be at risk or need special security or protection from the General Inmate Population? Such as:  - Having been assaulted, harassed, or coerced, sexually or otherwise, while in custody or during prior jail time?  - Having been perceived as being gay, or transgender, a cross dresser, or visibly feminine (if housed in male population)?  - Or any other reason?  Yes <input type="checkbox"/> No <input type="checkbox"/> Conflict <input type="checkbox"/>  _____  _____  _____						
	Are you now or have you ever been a law enforcement agent, police informant, political or public figure or member of a criminal or terrorist organization? (If Yes, specify) Yes <input type="checkbox"/> No <input type="checkbox"/> Conflict <input type="checkbox"/>  _____  _____  _____												
	I have been advised to answer all the questions in Section "E" accurately for my own well being and have responded as stated above. Inmate's Signature: _____ Date: _____												

		<b>CORRECTION DEPARTMENT CITY OF NEW YORK</b>		<b>Page 2 of 2 Pages</b>		<b>Form: ARC 239M Rev. : 11/29/18 Ref. : Dir. #4100R-D</b>						
		<b>ARRAIGNMENT AND CLASSIFICATION RISK SCREENING FORM</b>										
F	1. Do any documents indicate Suicide Watch and/or Protective Custody? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, authorization _____											
	2. Do you know of any other reason this inmate should be considered for special housing? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, specify _____											
	3. Complete for all State inmates, from N.Y.S. Custodial Transfer Form: <div>Maximum - A <input type="checkbox"/>    Maximum - B <input type="checkbox"/>    Medium - A <input type="checkbox"/>    Medium - B <input type="checkbox"/>    Minimum <input type="checkbox"/></div> If there is a "Yes," "Conflict," or "Maximum - A" response checked in Sections "E" or "F," print the name, rank and shield number of the supervisor notified: <div>Name _____ Rank _____ Shield # _____</div>											
G	Check off any of the charges listed below if indicated by the accompanying commitment papers as a current or prior charge (including attempts). In all cases where the charge against the inmate is 125.27 a mental health referral (clearly indicating the capital offense) will be filled out and submitted by the Intake Supervisor to the New Admission Intake Physician. <div><input type="checkbox"/> 105.17 - Conspiracy 1ST    <input type="checkbox"/> 200.45 - Bribe Public Official    <input type="checkbox"/> 240.06 - Riot 1ST <input type="checkbox"/> 125.27 - Murder 1ST    <input type="checkbox"/> 205.05 - Escape 3RD    <input type="checkbox"/> 263.10 - Promote Obscene Sex Performance W/Child <input type="checkbox"/> 130.35 - Rape 1ST    <input type="checkbox"/> 205.10 - Escape 2ND    <input type="checkbox"/> 263.15 - Promoting Sex Performance W/Child <input type="checkbox"/> 200.04 - Bribery 1ST    <input type="checkbox"/> 205.15 - Escape 1ST    <input type="checkbox"/> 120.11 - Aggravated Assault/Police/Peace Officer</div>						Number of Warrant(s) _____		Is Surety exam noted on the inmate's Securing Order? _____			
	Check "YES" if upon completion of this form the Inmate does not have any warrants or holds, and bail is the only factor resulting in continued custody, complete the "Bail Form" in accordance with Directive 1502 Bail Procedures <input type="checkbox"/> <b>YES, Inmate is Bail Eligible</b>						Check "NO" if upon completion of this form the Inmate has warrants or holds, and is not currently eligible to post bail for release from custody. <input type="checkbox"/> <b>NO, Inmate has current Warrants and/or Holds</b>					
	Name of Supervisor Notified if Any Charge Box(es) Above is Checked: _____				Rank: _____			Shield #: _____				
H	Preparing Officer's Signature: _____		Print Name Legibly: _____		Rank: _____		Shield #: _____					
I	<b>RECEIVING FACILITY STAFF</b>											
	To be completed by the screening officer. An individual shall be considered a "Street Gang Member" when they meet any of the following gang member identification criteria: * Admits membership* * Law enforcement or informant identifies individual as a gang member* * Individual is wearing gang clothing and/or symbols identifying with a specific gang* * Inmate has revealing tattoo(s) or marking(s) which may identify him/her as a member of a street gang (Describe in remarks section)* * Nature of arrest is indicated as street gang related activity or related incident*											
	1. Are you a member of or have you ever been a member of any street gang, cult, tribe, family group, or organization?						Yes <input type="checkbox"/>		No <input type="checkbox"/>			
	2. Have you ever been affiliated with any street gang, cult, tribe, family group, or organization?						Yes <input type="checkbox"/>		No <input type="checkbox"/>			
	3. Do you have any members of your family affiliated with any street gang, cult, tribe, family group, or organization?						Yes <input type="checkbox"/>		No <input type="checkbox"/>			
	4. Do you know of anyone who is a member of any street gang, cult, tribe, family group, or organization who is incarcerated?						Yes <input type="checkbox"/>		No <input type="checkbox"/>			
	5. Do you have any knowledge of any street gang, or jail gang activity?						Yes <input type="checkbox"/>		No <input type="checkbox"/>			
6. Do you have any other names [alias(es)] and/or nicknames that you are known by? (If Yes, list)						Yes <input type="checkbox"/>		No <input type="checkbox"/>				
* Use remarks section below to answer any "Yes" responses to questions listed above. Remarks: _____ _____ _____												
Interviewing Officer's Signature: _____					Date: _____							
J	<b>RECEIVING FACILITY SUPERVISOR</b>											
	1. Does this inmate meet any one of the gang affiliation identification criteria?						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	2. Has a Security Risk Group (SRG) card been initiated?						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	3. Is Protective Custody, Suicide Watch or a psychiatric examination (730) indicated on the commitment papers?						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	4. Does the inmate have any obvious physical injuries or exhibit signs of mental instability?						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	5. Has medical staff cleared this inmate for housing?						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	6. Does the inmate require special housing? (If Yes, specify type) _____						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	7. Is the housing designation assigned against the inmate's will?						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	8. Has the inmate been issued a notice report of right to due process form. (Whether the housing placement is voluntary or involuntary, the inmate must be issued a Notice of Right to Due Process Form.)						Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	9. If inmate is disabled (as indicated in Section B of this form) was Counseling Unit notified? Yes <input type="checkbox"/> No <input type="checkbox"/>											
If notified, specify date/time of notification and name of Counselor: Date: _____ Time: _____ Name: _____												
If not notified, information identifying disabled inmate must be forwarded to Counseling Unit on Form 3802D.												
Receiving Facility Supervisor's Initials: _____												
K	Has the inmate been permitted the opportunity to make a free phone call? (If Yes, indicate) Date: _____ Time: _____ Number Dialed: _____						Refused	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
L	The inmate's classification custody level is: Minimum <input type="checkbox"/> Medium <input type="checkbox"/> Maximum <input type="checkbox"/> Incomplete <input type="checkbox"/>											
M	Have you provided the above inmate with an IIS CC Screen printout for each active case(s) informing them of the bail condition(s) for each, as required?: Yes <input type="checkbox"/> _____ <div>Officer's Initials</div>											
N	Inmate's signature: _____						Signatures		Date		Time	
O	Receiving facility supervisor's signature: _____											
P	Inmate's signature upon discharge from court facility: _____											
Q	Court facility supervisor's signature upon discharge: _____											

**NYCHHC HIPAA Authorization to Disclose Health Information****ALL FIELDS MUST BE COMPLETED****THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS**

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER
NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested _____  Treatment Dates from _____ to _____	
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). <b>Please note: unless all of the boxes are checked, we may be unable to process your request.</b>  <input type="checkbox"/> Alcohol and/or Substance Abuse Program Information <input type="checkbox"/> Mental Health Information  <input type="checkbox"/> Genetic Testing Information <input type="checkbox"/> HIV/AIDS-related Information	
REASON FOR RELEASE OF INFORMATION <input type="checkbox"/> Legal Matter <input type="checkbox"/> Individual's Request <input type="checkbox"/> Other (please specify): _____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) <input type="checkbox"/> Event: _____ <input type="checkbox"/> On this date: _____	

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

***I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.***

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

**If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.**

<b>HHC USE ONLY</b>	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments: