

REASONABLE ACCOMMODATION REQUEST (RAR) FORM

If you have a disability and need help to take part in HRA programs and services, you may request a reasonable accommodation. Some examples of reasonable accommodations are scheduling appointments to avoid rush hour travel, priority appointments to minimize wait time at HRA offices, and assistance reading forms and notices. HRA provides reasonable accommodations to individuals with disabilities to ensure that such individuals receive meaningful access to HRA's programs, benefits and services.

INSTRUCTIONS AND INFORMATION
<p>➤ To assist HRA in making a determination on your request for a reasonable accommodation, please complete and submit pages 2, 3 and 4 of this form to:</p> <p style="text-align: center;">Human Resources Administration Office of Constituent Services (OCS) 150 Greenwich Street, 35th Floor New York, NY 10007</p> <p>You may also fax the forms to (212) 331-4685, email to ConstituentAffairs@hra.nyc.gov or submit your request to your worker.</p>
<p>➤ You must submit any medical documentation supporting your request with this form or within twenty (20) days of this request.</p>
<p>➤ Please ask your medical provider to complete and sign the Request for Medical Information Form (enclosed) or appropriate signed medical documentation on the medical provider's letterhead and return the form/documentation to you.</p>
<p>➤ You are responsible for returning your medical documentation to HRA in support of this request.</p>
<p>➤ If your medical or mental health conditions make it difficult for you to complete this form you may contact HRA at (212) 331-4640 for assistance.</p>
<p>➤ If your medical or mental health conditions make it difficult for you to gather medical documentation in support of your request, you must contact HRA at (212) 331-4640 for assistance. Please complete the enclosed HIPAA Authorization for the Disclosure of Individual Health Information (HRA-108 [E]) form and send it to the Office of Constituent Services at 150 Greenwich Street, 35th Floor, New York, NY 10007.</p>
<p>➤ HRA will mail you a confirmation number to acknowledge receipt of your Reasonable Accommodation Request.</p>
<p>➤ HRA will review all documentation provided by you and your medical provider and send you a written notice regarding our determination on your Reasonable Accommodation Request.</p>
<p>➤ In most cases, while HRA evaluates your request and makes a final determination, you will receive the reasonable accommodation you requested.</p>
<p>➤ If you are denied a reasonable accommodation or dissatisfied with an accommodation offered, you may file an appeal within twenty (20) days of the determination with the HRA ADA Compliance Officer. The determination form will provide you instructions for filing an appeal.</p>

REASONABLE ACCOMMODATION REQUEST (RAR) FORM

Name (Please Print): _____ **Case Number, if known:** _____

Social Security Number, if known: _____ **Telephone Number:** _____

Mailing Address: _____ **Center Number, if known:** _____

HRA Program Name, if known: _____

- 1) Have you been medically evaluated by HRA's WeCARE program within the last year? Yes No
- 2) Has an application for supportive housing (HRA 2010e) been submitted to HRA for you within the past year? Yes No
- 3) Do you receive federal disability benefits (SSI and/or SSDI)? Yes No
- 4) Do you receive Home Care Services or have a Home Attendant? Yes No

If you have answered "yes" to question 4, please indicate the number of hours you receive per day, the number of days per week for which you receive services and the reason(s) you receive home care services.

- 5) Describe your medical or mental health condition, the reasonable accommodation you are requesting and why you need it. (Attach additional sheets, if needed, and any medical information you choose to provide in support of your requested accommodation.)

Signature: _____ **Date:** _____

Print Name: _____

Authorized Representative's Signature: _____ **Date:** _____

Print Name: _____

REQUEST FOR MEDICAL INFORMATION FORM

INSTRUCTIONS FOR MEDICAL PROVIDER

Your patient has requested that the New York City Human Resources Administration (HRA) provide him/her with a reasonable accommodation/modification in order to receive meaningful access to HRA's programs, benefits and services. Please provide a detailed description of the specific physical and/or mental condition(s) that affects the patient's ability to perform certain tasks and engage in certain activities, any reasonable accommodation/modification needed and the relationship between the accommodation/modification and the patient's impairment. You may attach additional medical information to the forms as needed.

Please return this completed form to the patient.

Name of Patient (Please Print): _____

Date of Birth: _____

Social Security Number, if known: _____

Case Number, if known: _____

Name of Medical Provider: _____

Address of Medical Provider: _____

Telephone Number of Medical Provider: _____

1) Please state patient's medical and/or mental health condition(s):

2) Please provide a detailed description of the specific physical and/or mental health restrictions/limitations affecting the patient's ability to perform certain tasks and engage in certain activities. Please describe how the impairment affects the patient's daily functioning.

REQUEST FOR MEDICAL INFORMATION FORM (Continued)

- 3) Indicate whether the patient's condition(s) is permanent, chronic or temporary. If the patient's condition(s) is temporary, please state its anticipated duration.

- 4) Indicate what treatment if any the patient is currently receiving associated with his/her medical and/or mental health conditions(s) including, but not limited to, any medication or therapy.

- 5) Please describe the reasonable accommodation/modification needed by the patient and the relationship between it and client's medical and/or mental health conditions.

- 6) Does the patient's physical and/or mental health condition(s) make it difficult for the patient to perform the following activities? (If so, please fully describe the difficulties the patient has for each checked box):

Walking and/or Climbing Stairs. Describe: _____

Traveling and/or Taking Public Transportation. Describe: _____

Cognitive Functions (i.e. concentrating, remembering, understanding). Describe: _____

Sitting or Standing for extended periods of time. Describe: _____

Being in crowded places. Describe: _____

Medical Provider's Signature: _____

Date: _____

Medical Provider's License number: _____