



THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION



DIRECTIVE

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| [] NEW [] INTERIM [X] REVISED | | | SUBJECT | | |
| EFFECTIVE DATE 11/30/18 | | *TERMINATION DATE / / | NON-DISCRIMINATION OF INMATES WITH DISABILITIES | | |
| CLASSIFICATION # 3802R-A | SUPERSEDES 3802 | DATED 12/15/05 | APPROVED FOR WEB POSTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | DISTRIBUTION B | PAGE 1 OF 19 PAGES |
| RECOMMENDED FOR APPROVAL BY REVIEW BOARD MEMBER <i>Hazel Jennings</i> | | | AUTHORIZED BY THE COMMISSIONER <i>Cynthia Brann</i> | | |
| HAZEL JENNINGS, CHIEF OF DEPARTMENT SIGNATURE | | | CYNTHIA BRANN 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 inmates 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 processes for reasonable accommodations, the identification of inmates with disabilities in the Department's custody, the role of the Department's Disability Rights Coordinator for Inmates (DRCI) and other staff, and policies concerning other issues that arise relating to inmates with disabilities.

II. POLICY

- A. The Department shall not discriminate against any inmate on the basis of his or her disability or deny an inmate with a disability from participating in services, programs, or activities based on his or her disability. The Department will provide reasonable accommodations or make reasonable modifications to existing policies and procedures that are consistent with legitimate penological interests in order to afford inmates 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 as individual inmates request reasonable accommodations.
- B. The Department will take appropriate steps to ensure that effective communication is provided for individuals with disabilities (including inmates with hearing or vision impairments, and those with intellectual, psychiatric, learning and/or speech disabilities). The obligation to provide effective communication shall also 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



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II. POLICY (Cont.)

- security efforts to prevent, detect and respond to sexual abuse and sexual harassment.
- C. Inmates 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 for such an area by a health care provider and are receiving medical care and treatment.
- D. The Department shall educate staff and inmates regarding its zero-tolerance policy for discrimination against inmates with disabilities, shall provide training on disability sensitivity/awareness issues to optimize interaction and communication with inmates with disabilities, and shall provide instructions on assisting inmates to access auxiliary aids and services.
- E. The Department will ensure that procedures are in place for inmates with disabilities to request reasonable accommodations and make disability related complaints and to prohibit unlawful treatment based on disability.

III. DEFINITIONS

- A. Assistive Devices – Devices that assist inmates 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 inmates 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 inmate entitled to an accommodation or who may be entitled to an accommodation under the law, engage in good faith written or oral dialogue concerning the inmate's accommodation needs; potential accommodations that may address the inmate's accommodation needs, including alternatives to a requested accommodation; and the difficulties that such potential accommodations may pose for DOC.
- D. Disability As defined in the Americans with Disabilities Act (42 USC § 12102(2); 28 CFR § 35.104), the term "disability" means:

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III. DEFINITIONS (Cont.)

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 inmate, or by another person on behalf of an inmate, 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 inmate policies and procedures, the physical environment, formats for receiving information, or the manner in which tasks are carried out, that enable an inmate with a disability to have equal access to and participate in a service, program, activity or use of a facility.

IV. STAFF RESPONSIBILITIES

Department Staff:



- A. Disability Rights Coordinator for Inmates – The Disability Rights Coordinator for Inmates (DRCI) or his/her designee shall:
1. Ensure that policies, practices, or procedures are in place, publicized, and implemented for the prompt and equitable resolution of requests for

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IV. STAFF RESPONSIBILITIES (Cont.)



accommodations submitted by inmates 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 individual regarding a denial or modification of a request for a reasonable accommodation;
3. Visit inmates with disabilities including those who have requested or been granted reasonable accommodations to ensure the Department's compliance with legal requirements pertaining to individuals with disabilities. Visits will be recorded in the facility logbooks and in the DRCI's records.
4. Monitor housing assignments of inmates with disabilities and alert the Deputy Commissioner when an assignment appears not to be appropriate for an inmate 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 inmates under the ADA and the City Human Rights Law;
6. Serve as a resource for inmates, other Department employees, and representatives of federal, state, and city government agencies who have questions or concerns regarding inmates 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 inmates with disabilities, as reported weekly by all facilities, to keep track of all inmates 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 inmates with disabilities and disability related complaints with appropriate personnel throughout the Department and/or other agencies including:
 - a. Cooperative dialogue with the inmate
 - b. Evaluation of the inmate by qualified experts, as necessary.
 - c. Transfer of the inmate to an appropriate facility, or relocations within a facility.

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- d. The inmate'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 Department staff who interact with inmates 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 of Programs – The Deputy Warden of Programs shall:
1. Serve as a liaison between inmates in the facility and the DRCI or his/her designee. However, nothing in this section shall prevent an inmate from contacting the DRCI or his/her 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 his/her attention by the DRCI or other staff.
 3. Notify the DRCI or his/her designee in writing within two business days of inmate reasonable accommodation requests or disability-related complaints submitted to the Department, including both written requests or complaints that are subject to review by the DRCI and instances where a request or complaint is addressed informally at the facility level. The DRCI will also be responsible for tracking those requests addressed directly at the facility level.
- C. Social Service Counselors and/or Grievance Coordinators shall:
1. Inform an inmate with a disability of available services, including offering assistance with the reasonable accommodation process and completion of forms.

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IV. STAFF RESPONSIBILITIES (Cont.)

2. Serve as a liaison between inmates making a disability related complaint or requesting a reasonable accommodation and the DRCI and his/her designee and the Deputy Warden for Programs or his/her designee at a facility.
3. Meet and address the questions or concerns of inmates with disabilities at the facility level, as identified by the Intake Captain, Deputy Warden of Programs and/or the DRCI, or his/her 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 DRCI, or his/her designee
5. Communicate with inmates and their representatives, using auxiliary aids and services as needed, and follow up on disability related complaints or reasonable accommodation requests referred by the DRCI, including providing inmates with status updates on reasonable accommodation requests.



V. PRIVACY

Department staff are instructed not to disclose any information concerning an inmate's disability status to other inmates 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 inmate with a disability receives the reasonable accommodations that he or she needs, 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 inmate is received at a Department court detention facility or as a direct admission to a Department facility, the staff member processing the inmate for admission shall, in the course of filling out the Arraignment and Classification Risk Screening Form (Form ARC 239M), inquire whether the inmate has a disability, and whether the inmate is requesting a reasonable accommodation, and shall note the inmate's response on the Form. If the response to either or both questions is in the affirmative,

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VI. PROCEDURES (Cont.)

and/or it is apparent that the inmate has a disability (for example, because the inmate uses a wheelchair) the staff member shall notify the DRCI or his/her designee and the Deputy Warden of Programs in writing within two (2) business days.

- b. Upon intake, the Department may temporarily take an inmate'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 such a security risk, as long as Correctional Health Services (CHS) promptly evaluates the inmate to ensure that the alternative device meets the inmate's needs. For example, CHS may give an inmate a wooden cane to replace a metal cane provided that CHS determined that would meet the inmate's needs.
2. Notice to Captains, Social Services Counselor/Grievance Coordinator and Disability Rights Coordinator
 - a. When an inmate 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 his/her designee, shall immediately notify the facility Social Services Counselor/Grievance Coordinator, the Deputy Warden for Programs or his/her designee, and the Disability Rights Coordinator for Inmates or his/her designee, in writing on Form 3802D. The notification to all interested parties shall include the inmate's name, NYSID number, Book & Case number, the nature of the inmate's disability, if known to the Department, and any request for accommodation made by that inmate at Intake.
 - b. Should inmate(s) known to the Department to have disabilities be admitted to the facility outside of regular business hours, the Intake Area Captain shall forward a list on Form 3802D (Notification to Counseling Services Unit) to the Counseling Services Unit, the Deputy Warden for Programs or his/her designee, and the DRCI or his/her designee, containing each inmate's name, NYSID number, Book & Case number, nature of disability, if known to the Department, and accommodation requested, and housing location. This list must be prepared and forwarded prior to the completion of the Captain's tour of duty.
 - c. The Department will receive notice from CHS, after CHS has conducted an intake assessment, of any assistive device that an inmate needs because of a disability, and any recommendation for special housing that is appropriate in light of an inmate's disability.

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3. Intake Visit by Social Services Counselor and/or Grievance Coordinator and/or Disability Rights Coordinator



Upon being notified of the admission of an inmate with a disability, a Social Services Counselor/Grievance Coordinator and the DRCI, or his/her designee, shall confer and make arrangements to meet with the inmate as soon as practicable to inform the inmate of all services and programs that are available to inmates with disabilities.

B. Requests for Accommodation or Disability Related Complaint Made Post Intake.

1. An inmate, or any other individual on an inmate's behalf, may request a reasonable accommodation or make a disability related complaint by any of the following methods:
 - a. An inmate, or any other individual on an inmate's behalf, may complete an Inmate Reasonable Accommodation Request ("IRAR") 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 for Inmates or his/her designee. IRAR forms may be obtained from multiple areas including: intake areas, housing areas, the Counseling Services Unit, Medical Clinics and Law Libraries.
 - b. An inmate, or any other individual on an inmate's behalf, may call the DRCI on the dedicated phone line.
 - c. An inmate, or any other individual on an inmate's behalf, may complete a request via Service Desk with a Grievance Coordinator.
 - d. An inmate, or any other individual on an inmate's behalf, may call 311.
 - e. An inmate, or any other individual on an inmate's behalf, may mail a written request to the DRCI or his/her designee.
 - f. An inmate, or any other individual on an inmate'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 inmate (or a person acting on the inmate's behalf), will be asked to complete the Inmate Reasonable Accommodation Request Form (IRAR), (Form 3802A).

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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 inmate (or a person acting on the inmate's behalf), will be asked to complete the Inmate Reasonable Accommodation Request Form (IRAR), (Form 3802A) later.
3. If medical information is needed to respond to the request or complaint, the inmate shall also be provided with a HIPAA authorization form, with an explanation that (1) the inmate's decision to sign the form or not will not affect any medical examination to be conducted, access to treatment, or any recommendation for a reasonable accommodation, and (2) the inmate's decision to sign it would enable the Department to discuss the inmate'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 DRCI or his/her designee immediately upon completion. The communication to the DRCI or his/her designee shall include the name of the facility, the inmate's name, NYSID number, Book & Case number, housing area, the nature of the inmate's disability, if known to the Department, and any request for accommodation or disability related complaint made by that inmate.
5. If the contact with the DRCI or his/her designee regarding an inmate with a disability is made by phone, a written memo that includes the above information shall be prepared by the DRCI or his/her designee. Records of all such written communication shall be maintained in the Counseling Services Unit and/or Grievance Unit and by the DRCI or his/her designee.
6. The Social Services Counselor, Grievance Coordinator or other available staff shall assist inmates in completing the IRAR Form (Form #3802A) and the HIPAA form whenever necessary, including, but not limited to, when assistance is necessary because of the inmate's disability. The staff member who first receives the IRAR form will forward it to the DRCI or his/her designee, who will then forward an acknowledgement to the inmate by signing and dating the form in the space provided, and by providing a copy to the inmate.
7. Upon receipt of a reasonable accommodation request or disability related complaint, the DRCI or his/her designee shall enter it into a request tracking database such as Service Desk and/or any other accepted tracking mechanism.
8. The DRCI or his/her designee shall provide the inmate 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

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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 will also be sent to individuals who have submitted requests on behalf of an inmate pursuant to this Directive.



- D. Reviewing and Making Determinations on Accommodation Requests and Disability Related Complaints.
1. The DRCI or his/her designee shall be responsible for reviewing and making determinations on all requests for accommodations and disability related complaints made to the Department. The DRCI or his/her designee shall consult as needed with CHS, the Deputy Warden of Programs or the Warden.
 2. The DRCI or his/her designee shall engage in a cooperative dialog with the inmate about the request for reasonable accommodation. This shall occur within five business days of receipt of the request for accommodation or disability related complaint, absent exceptional circumstances that shall be documented. The DRCI or his/her designee shall consider the inmate's preference as to the type of accommodation to be provided, and request additional information if what is being sought is not clear or if 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 inmate with a disability. The Department shall provide a reasonable accommodation for an inmate who needs it unless doing so would result in a fundamental alteration to the nature of a service, program, or activity or compromise the safety or security of inmates or the facility. While the Department shall give primary consideration to the specific accommodation or auxiliary aid/service requested by the inmate, 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 inmates or the facility, the Department shall seek to provide an alternative accommodation that will ensure that the inmate has equal access to programs, activities, and services.
 4. The Department shall allow an inmate to be seen at CHS for evaluation of the need for accommodation. CHS shall notify DRCI or his/her 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 will seek to provide an accommodation that does not present

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such an alteration. If the Department does not follow a CHS recommendation, it will notify CHS.

5. The DRCI or his/her designee shall provide the inmate with a written notification of the determination 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 inmate of his/her right to appeal the decision to the Deputy Commissioner for Health Affairs by completing Form 3802E, "Inmate 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 inmate, 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 inmate authorizing disclosure of such information.
 6. The DRCI shall communicate all decisions made pursuant to this section, in writing to the Social Services Counselor and/or Grievance Coordinator, and the Deputy Warden of Programs, and record the determination in the Department's tracking system.
 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 inmate, time needed to procure assistive devices, or a trial that make reaching a determination within such time impracticable, in which case the DRCI or his/her designee shall document these exceptional circumstances, inform the inmate 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 possible.
- E. Implementing a Reasonable Accommodation That Has Been Approved by the Department.
1. The Deputy Warden of Programs shall notify his/her 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.

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3. The DRCI, or his/her 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 DRCI shall provide status updates to the inmate every ten (10) business days thereafter until the approved accommodation has been implemented. The DRCI, or his/her designee, shall advise the Deputy Commissioner for Health Affairs of any failure to timely provide an approved accommodation.
 4. When an inmate 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 inmate whose assistive device needs maintenance, repair or replacement may bring the matter to the attention of the DRCI, his/her 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 inmate'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 inmates. CHS provides assistive devices directly to inmates. CHS maintains records as to when inmates may need to be reexamined to determine whether their need for an accommodation or an assistive device is continuing.
 2. CHS notifies the Department of the inmate's need for an accommodation or an assistive device by sending a notice to the Deputy Warden and the DRCI that includes the date of medical appointment, information regarding whether any assistive devices were provided to the inmate, whether any other reasonable accommodation for the inmate's disability (for example, special housing) is recommended, and the length of time for the accommodation.
 3. The Department makes the final determination as to an inmate'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.

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1. When CHS does not approve an assistive device an inmate requested, and/or when the inmate has any complaint relating to a reasonable accommodation provided or not provided by CHS or the Department, the inmate, or an individual acting on the inmate's behalf, may notify the DRCI or his/her designee of the denial by CHS, using any of the methods described in Section VI. B.
 2. The DRCI or his/her designee may refer the inmate to CHS, or any other expert, for a second opinion about the need for the device.
 3. The inmate may be asked to provide the Department with a HIPAA authorization to enable the Department to review CHS documentation and discuss the inmate's request with CHS personnel or other experts.
 4. The DRCI or his/her designee will notify the inmate in writing about the resolution of the request. If the request was submitted by an individual on behalf of the inmate, 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 inmate authorizing disclosure of such information.
- H. Questions about Continuing Need for or Improper Use of an Accommodation or Assistive Device
1. If the Department believes that an inmate has an assistive device or is receiving an accommodation that is not needed, the Department may refer the inmate to CHS for a follow-up examination to determine if the device or accommodation is still medically necessary. The Department will notify CHS of the reason for the referral, and inform the DRCI or his/her designee.
 - a. If CHS confirms the need for the assistive device or accommodation, the Department will allow the inmate 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 inmate 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 inmate agrees to be reexamined.
 - d. The DRCI shall provide the inmate 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.

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2. If the Department has reason to believe that an inmate is using an assistive device or medical equipment in a manner that raises security concerns or poses a threat to the safety of staff, inmates, or others, the Department may confiscate the device or equipment and will immediately refer the inmate 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 inmate's device or equipment is confiscated, the facility's Deputy Warden of Security, medical staff, and the DRCI 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 inmate's medical status and need for the device or medical equipment.
 - a. If CHS confirms the need for the device or equipment, the Department will return the device or equipment to the inmate, unless the facility's Warden or his/her 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 of equipment will be provided to the inmate.
 - b. If CHS does not confirm the need for the device, the Department does not need to return it to the inmate and an infraction may be generated pursuant to the conduct observed. The Department will inform the DRCI or his/her designee if a device is confiscated.
 - c. The DRCI shall provide the inmate a written explanation of the reason for the confiscation or any substitute, and notice of the right to appeal.
3. An inmate whose device has been confiscated or substituted shall have the right to appeal within ten (10) days by completing Form 3802E, "Inmate Appeal of Reasonable Accommodation Determination" (Attachment E).
 - I. Appeal
 1. An inmate 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, "Inmate Appeal of Reasonable Accommodation Determination" (Attachment E) within ten (10) days of receipt of the written determination from the DRCI or his/her designee.

| | | | | |
|---|------------------------------------|---|--------------------------------------|---|
|  | EFFECTIVE DATE 11/30/18 | SUBJECT NON-DISCRIMINATION OF INMATES WITH DISABILITIES | |  |
| | CLASSIFICATION # 3802R-A | | | |
| | DISTRIBUTION B | APPROVED FOR WEB POSTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | PAGE 15 OF 19 PAGES | |

VI. PROCEDURES (Cont.)



2. The Deputy Commissioner of Health Affairs, or his/her designee, shall review the appeal and issue a written decision. He or she shall review all documents relating to the appeal including, but not limited to, documents provided by the inmate in support of the requested accommodation and documents relied upon by the DRCI or his/her designee in making the determination, including all relevant medical records that the inmate 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 for Health Affairs using form 3802F, "Appeal Determination for Inmate 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 his/her designee, shall ensure that his/her determination regarding the appeal is delivered to the inmate as soon as possible after its issuance.

VII. RECORD KEEPING

The DRCI keeps a weekly log of inmates with disabilities in the Department's custody developed from weekly reports received from CHS at each facility. Information tracked in the log includes an inmate'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, and use of a prosthesis, walker, crutches, cane, part-time or full-time wheelchair.

VIII. ACCOMMODATIONS AND AUXILIARY AIDS

- A. Auxiliary aids and services shall be available for inmates 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.

| | | | | |
|---|------------------------------------|---|--------------------------------------|---|
|  | EFFECTIVE DATE 11/30/18 | SUBJECT NON-DISCRIMINATION OF INMATES WITH DISABILITIES | |  |
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VIII. ACCOMMODATIONS AND AUXILIARY AIDS (Cont.)

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
12. Mobility assistive devices
13. Accessible transportation

IX. NOTIFICATION / COMMUNICATION

A. PUBLICIZING INMATE PROCEDURES



1. A poster, in multiple languages per New York City Local Law 30, notifying inmates of the name, address and phone number of the Disability Rights Coordinator for Inmates, the Social Services Counselor and/or Grievance Coordinator assigned to each facility, and an explanation of the rights of inmates with disabilities to request a reasonable accommodation or filed 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 Inmate Handbook that is provided to each inmate at Intake, including information describing his or her rights under the ADA. How to submit a request for accommodation or disability related complaint; the name and contact information for the DRCI, and the resources available for inmates with visual, hearing, mobility, or other impairments. DOC will provide such materials in large print and in Braille for inmates with visual impairments.

| | | | | |
|---|------------------------------------|---|--------------------------------------|---|
|  | EFFECTIVE DATE 11/30/18 | SUBJECT NON-DISCRIMINATION OF INMATES WITH DISABILITIES | |  |
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| | DISTRIBUTION B | APPROVED FOR WEB POSTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | PAGE 17 OF 19 PAGES | |

IX. NOTIFICATION / COMMUNICATION (Cont.)

B. ENSURING EFFECTIVE COMMUNICATION

1. The Department will provide materials in alternate formats to ensure proper notification to inmates 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 inmates who are deaf, hard of hearing, or who have a speech disability.
 - 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 and vocational, and entertainment programming;
 - g. Due process hearings, including disciplinary hearings, and hearings in which the inmate 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. Inmate reasonable accommodation process;
 - o. Emergency preparedness practice;

| | | | | |
|---|------------------------------------|---|--------------------------------------|---|
|  | EFFECTIVE DATE 11/30/18 | SUBJECT NON-DISCRIMINATION OF INMATES WITH DISABILITIES | |  |
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IX. NOTIFICATION / COMMUNICATION (Cont.)



- p. Employment;
- q. Recreational programs.

X. REFERENCES

- A. Operations Order #28/89, Identification of Hearing Impaired/Deaf Mute Inmates, dated 6/19/89 (as amended).
- B. Directive 5011, Elimination of Sexual Abuse and Sexual Harassment, dated 5/2/16 (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, "Inmate 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, "Inmate Appeal of Reasonable Accommodation Determination"
- F. Form 3802F, "Appeal Determination for Inmate Reasonable Accommodation Request"
- G. Form 3802G, "Confiscation of Assistive Devices"
- H. Form ARC 239M, "Arrest and Classification Risk Screening Form" dated 11/29/18.
- I. Health Insurance Portability and Accountability Act (HIPAA) Form

| | | | | |
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|  | EFFECTIVE DATE 11/30/18 | SUBJECT NON-DISCRIMINATION OF INMATES WITH DISABILITIES | |  |
| | CLASSIFICATION # 3802R-A | | | |
| | DISTRIBUTION B | APPROVED FOR WEB POSTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | PAGE 19 OF 19 PAGES | |

XII. SUPERSEDES

- A. Directive 3802, Reasonable Accommodation for Inmates with Disabilities, dated 12/15/05.
- B. Any other Directive, Operations Order, Teletype, Memorandum, etc., that may be in conflict with the policies and procedures outlined herein.

XIII. SPECIAL INSTRUCTIONS

- A. Within ten (10) days of the effective date of this order Commanding Officers of Facilities and Divisions shall 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 Supervising Warden.
- C. Commanding Officers of Facilities and Divisions shall ensure that the provisions of this Operations Order are strictly complied with.



**CORRECTION DEPARTMENT
CITY OF NEW YORK**



**INMATE REASONABLE
ACCOMMODATION REQUEST (IRAR)**

Form: 3802A
Eff. : 11/30/18
Ref. : Dir. #3802R-A

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 Inmate 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 inmate in completing this form.

| | | |
|---------------------|----------------------|-------------------|
| Inmate's Last Name: | Inmate'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 Prison 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 an accommodation.

Inmate'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 an accommodation may be denied for this reason.

Inmate'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.I.C.
and facility Deputy Warden for Programs for a determination.**



**CORRECTION DEPARTMENT
CITY OF NEW YORK**



**ACKNOWLEDGEMENT OF REQUEST
FOR REASONABLE ACCOMMODATION**

Form: 3802B
Eff. :11/30/18
Ref. : Dir. #3802R-A

Inmate's Last Name:

Inmate's First Name:

Date:

NYSID #:

Book & Case #:

Facility:

Housing Area:

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

Below section to be completed by the Disability Rights Coordinator for Inmates (DRCI) or Deputy Warden for Programs

Acknowledgement:

Signature of DRCI or Deputy Warden of Programs

Date



**CORRECTION DEPARTMENT
CITY OF NEW YORK**



**DETERMINATION OF REQUEST
FOR REASONABLE ACCOMMODATION**

Form: 3802C
Eff. : 11/30/18
Ref. : Dir. #3802R-A

Inmate's Last Name: _____ Inmate's First Name: _____ Date: _____

NYSID #: _____ Book & Case #: _____ Facility: _____ Housing Area: _____

If Form A is not complete, the inmate must complete the information below:

Information to be added to Form A:

Inmate's Signature: _____ Date: _____

Disability Rights Coordinator for Inmates Determination (DRCI)

Approved Denied Modified _____ _____
Initials Date

Specific accommodation provided:

Explanation of modification or denial (if applicable):

Explanation of delay, if any:

DRCI's Signature: _____ Date: _____

Inmate's Signature: _____ Date: _____

Served to inmate by:

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



**CORRECTION DEPARTMENT
CITY OF NEW YORK**



**NOTIFICATION TO COUNSELING
SERVICES UNIT**

Form: 3802D
Eff. : 11/30/18
Ref. : Dir. #3802R-A

Should an inmate 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 his/her designee, containing each inmate'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 Inmate | NYSID # | Book & Case # | Housing Location | Disability | Accommodation Requested |
|----------------|---------|---------------|------------------|------------|-------------------------|
| | | | | | |
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| | | | | | |
| | | | | | |

Signature: _____



CORRECTION DEPARTMENT
CITY OF NEW YORK



INMATE APPEAL OF REASONABLE
ACCOMMODATION DETERMINATION

Form: 3802E
Eff. : 11/30/18
Ref. : Dir. #3802R-A

| | | |
|---------------------|----------------------|-------|
| Inmate's Last Name: | Inmate's First Name: | Date: |
|---------------------|----------------------|-------|

| | | |
|----------|----------------|-------------------|
| NYSID #: | Book & Case #: | Facility/Housing: |
|----------|----------------|-------------------|

Accommodation Request:

| | |
|------------------|------------------------|
| Date of Request: | Date of Determination: |
|------------------|------------------------|

Determination:

| |
|-----------------|
| Date of Appeal: |
|-----------------|

Reason for Appeal:

Inmate Signature: _____ Date: _____

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

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



**CORRECTION DEPARTMENT
CITY OF NEW YORK**



**APPEAL DETERMINATION FOR INMATE
REASONABLE ACCOMMODATION REQUEST**

Form: 3802F
Eff. : 11/30/18
Ref. : Dir. #3802R-A

| | | |
|---------------------|----------------------|-------|
| Inmate's Last Name: | Inmate's First Name: | Date: |
|---------------------|----------------------|-------|

| | | |
|----------|----------------|-------------------|
| NYSID #: | Book & Case #: | Facility/Housing: |
|----------|----------------|-------------------|

| | |
|----------|---------------|
| Request: | Request date: |
|----------|---------------|

Appeal Request:

Inmate's Signature: _____ Date: _____

Determination of Deputy Commissioner/ Health Affairs:

Approved

 Denied

 Modified

Specific accommodation provided:

Signature of D/C Health Affairs: _____ Date: _____

Served upon inmate by:

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



**CORRECTION DEPARTMENT
CITY OF NEW YORK**



CONFISCATION OF ASSISTIVE DEVICES

Form: 3802G
Eff. :11/30/18
Ref. : Dir. #3802R-A

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

| | | |
|---------------------|----------------------|-------|
| Inmate's Last Name: | Inmate's First Name: | Date: |
|---------------------|----------------------|-------|

| | | | |
|----------|----------------|-----------|---------------|
| NYSID #: | Book & Case #: | Facility: | Housing Area: |
|----------|----------------|-----------|---------------|

Assistive Device:

Date Assistive Device Confiscated: _____

Reason for Confiscation:

Staff Member who Confiscated Assistive Device:

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

Was inmate referred to medical provider for reevaluation? Yes No

If no, give reason: _____

| | | |
|-------------------------|--------------------------|------------------------|
| Supervisor's Last Name: | Supervisor's First Name: | Supervisor's Shield #: |
|-------------------------|--------------------------|------------------------|

Signature of Supervisor _____
Date

Copies to: (1) Inmate; (2) Inmate's file; (3) Counseling Services Unit; (4) Deputy Warden for Programs; (5) Deputy Warden for Security; (6) Disability Rights Coordinator for Inmates



**CORRECTION DEPARTMENT
CITY OF NEW YORK**

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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 No CMC: Yes No
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 EXPEDITED

Do you have immediate medical needs? (if yes, specify) Yes No _____ Does Securing Order/Commitment Papers indicate medical/mental health attention requested? Yes No

Do you have any of the following symptoms?: Fever - Yes No Cough - Yes No Sore Throat - Yes No

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 No _____ Are you requesting a reasonable accommodation? (If Yes, specify) Yes No _____

| 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 Female Transgender Male Transgender Female

Race: American Indian or Alaska Native Asian African American Hispanic White Other _____

Complexion: Light Medium Dark Nativity: _____ U.S. Citizen: Yes No Height: _____ Weight: _____

Religion: _____ Marital Status: _____ Drug Abuser? (If Yes, specify): Yes No _____ Alcohol Abuser: Yes No Detox: Yes No Shoe Size: _____

Arrest date: _____ Arrest Number: _____ Eye color: _____ Hair color: _____ 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 No _____ Level of Education: _____ Social Security #: _____

Occupational skills: (If Yes, specify) Yes No _____ Served in the military: (If Yes, indicate branch, unit and special skills) Yes No _____

E

Is this the first time you have been held in jail or custody? Yes No Conflict

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 No Conflict

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 No Conflict

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: _____



**CORRECTION DEPARTMENT
CITY OF NEW YORK**

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Form: ARC 239M
Rev. : 11/29/18
Ref. : Dir. #4100R-D



ARRAIGNMENT AND CLASSIFICATION RISK SCREENING FORM

F

1. Do any documents indicate Suicide Watch and/or Protective Custody? No Yes If Yes, authorization _____

2. Do you know of any other reason this inmate should be considered for special housing? No Yes If Yes, specify _____

3. Complete for all State inmates, from N.Y.S. Custodial Transfer Form:
 Maximum - A Maximum - B Medium - A Medium - B Minimum

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:

| | | |
|------|------|----------|
| Name | Rank | Shield # |
|------|------|----------|

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.

| | | | | |
|--|---|---|----------------------|--|
| <input type="checkbox"/> 105.17 - Conspiracy 1ST | <input type="checkbox"/> 200.45 - Bribe Public Official | <input type="checkbox"/> 240.06 - Riot 1ST | Number of Warrant(s) | Is Surety exam noted on the inmate's Securing Order? |
| <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 | | |

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

YES, Inmate is Bail Eligible

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.

NO, Inmate has current Warrants and/or Holds

| | | |
|---|-------|-----------|
| Name of Supervisor Notified if Any Charge Box(es) Above is Checked: | Rank: | Shield #: |
|---|-------|-----------|

H

| | | | |
|--------------------------------|---------------------|-------|-----------|
| Preparing Officer's Signature: | Print Name Legibly: | Rank: | Shield #: |
|--------------------------------|---------------------|-------|-----------|

RECEIVING FACILITY STAFF

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 No

2. Have you ever been affiliated with any street gang, cult, tribe, family group, or organization? Yes No

3. Do you have any members of your family affiliated with any street gang, cult, tribe, family group, or organization? Yes No

4. Do you know of anyone who is a member of any street gang, cult, tribe, family group, or organization who is incarcerated? Yes No

5. Do you have any knowledge of any street gang, or jail gang activity? Yes No

6. Do you have any other names [alias(es)] and/or nicknames that you are known by? (If Yes, list) Yes No

* Use remarks section below to answer any "Yes" responses to questions listed above.

Remarks: _____

Interviewing Officer's Signature: _____ Date: _____

RECEIVING FACILITY SUPERVISOR

| | | | | |
|---|-----|--------------------------|----|--------------------------|
| 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) Refused Yes No

Date: _____ Time: _____ Number Dialed: _____

L

The inmate's classification custody level is: Minimum Medium Maximum Incomplete

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 _____
Officers' Initials

N

| Signatures | Date | Time |
|---------------------|------|------|
| Inmate's signature: | | |

O

Receiving facility supervisor's signature:

P

Inmate's signature upon discharge from court facility:

Q

Court facility supervisor's signature upon discharge:



ATTACHMENT - I

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). Please note: unless all of the boxes are checked, we may be unable to process your request. <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.

| HHC USE ONLY | |
|-----------------|--|
| Date Received: | Initials of HIM employee processing request: |
| Date Completed: | Comments: |