MARCUS J. MOLINARO
COUNTY EXECUTIVE

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DIRECTOR

COUNTY OF DUTCHESS

HUMAN RESOURCES
DIVISION OF RISK MANAGEMENT

M E M O R A N D U M

TO: All Department Heads and Elected Officials

FROM: George L. Salem, Jr., Director of Risk Management GLS

DATE: March 4, 2021

RE: Americans with Disabilities Act (ADA)

Risk Management has taken over the processing of ADA applications, please be advised:

- Applicants should be directed to the County Website to apply https://www.dutchessny.gov/Departments/Human-Resources/Docs/ADA-Employee-Packet.pdf
- or the **County Intranet** (policies and procedures, ADA employee packet) at http://mydci.dcny.gov/CountyPolicies/ADA-Employee-Packet.pdf.
- The completed application paperwork should be sent to Risk Management at 22 Market Street or emailed to ADArequests@dutchessny.gov.
- Once the application has been received, Risk Management will contact the department to determine if a temporary accommodation is necessary. This will be determined on a case by case basis.
- If it is determined that a temporary accommodation is both necessary and feasible a "7 day" temporary accommodation will be granted.
- Additional 7 day extensions may be granted on a case by case basis if necessary, to complete the ADA process.

The process will require effective communication between the department and Risk Management to facilitate timely processing of all applications. Please share this with your leadership teams and call me or Jessica Barry if you have any questions. (845) 486-2169

Request for Accommodation Based on Disability

Americans with Disabilities Act (ADA)

☐ Current County Employee	☐ Job Applicant
Date: _____	Department: _____
Name: _____	Title: _____
Address: _____	Work Location: _____
_____	Supervisor: _____
Personal Phone: _____ ☐	Work Phone: _____ ☐
Personal E-mail: _____ ☐	Work Email: _____ ☐

Please check the box for preferred method of contact.

1. What is the disability that requires you to seek an accommodation (NOTE: this is not asking for the medical diagnosis/medical condition; please describe the disability/limitation, e.g. I have a condition that affects my ability to "X").

2. How does the above disability impact your ability to perform the functions of your job? OR What accommodation are you asking for to assist you in the recruitment and interview process?

3. What accommodation are you requesting to overcome the above to allow you to perform the functions of your job?

4. Please indicate the type of the accommodation you are seeking.

Temporary ☐ Date Range From:_____ To:_____

Permanent ☐ For the duration of employment with the County.

Have you had a previous accommodation for this same limitation? Yes ☐ No ☐

Date of previous accommodation:_____

Request for Accommodation *continued*

Please provide any additional information that might be useful in processing your request for an accommodation.

_____ _____

Employee/Applicant Signature *Date*

NOTICE OF RECEIPT OF ACCOMMODATION REQUEST:
Your request for an accommodation pursuant to the Americans with Disabilities Act (ADA) has been received by Risk Management/Human Resources on _____.
Based on the information provided please be advised as follows: 1. ☐ YOUR ACCOMMODATION IS BEING GRANTED AS REQUESTED Request Details: _____ _____ Duration: _____ Frequency: _____ 2. ☐ A *TEMPORARY* ACCOMMODATION IS BEING PROVIDED* Temporary Request Details: _____ _____ Duration: _____ Frequency: _____ 3. ☐ A DETERMINATION CANNOT BE MADE AT THIS TIME; ADDITIONAL INFORMATION NEEDED ☐
***NOTE:** For #2 and #3, a Safety Specialist will be in contact with you to discuss the additional clarification or information needed in order for a final determination to be made by the ADA Review Committee. After your complete request has been reviewed by the ADA Committee, you will be informed in writing of the determination. You can anticipate a decision will be made by no later than 30 days of receipt of all the required documentation.
Should you have any questions, please contact _____, Safety Specialist at (845) 486-_____.

Revised: 7/27/2021

FORM #2

REQUEST FOR ACCOMMODATION STATUS FORM

Americans with Disabilities Act (ADA)

Employee/Applicant: _____

Department: _____ Title: _____

Accommodation Request Dated: _____

1. ☐ **ACCOMMODATION IS BEING GRANTED AS REQUESTED***
   *SEE EXPLANATION/DETAILS ON THE BACK OF THIS FORM:

2. ☐ **ALTERNATIVE ACCOMMODATION OPTIONS OFFERED***
   *SEE EXPLANATION/DETAILS ON THE BACK OF THIS FORM:

3. ☐ **YOUR ACCOMMODATION CANNOT BE GRANTED BECAUSE**

   a. ☐ You do not have a qualifying disability under the federal requirements of the ADA
   The ADA defines a disability to mean: *(1) a person who has a physical or mental impairment that substantially limits one or more major life activities, (2) a person with a record of a physical or mental impairment that substantially limits one or more major life activities, and (3) a person who is regarded as having a physical or mental impairment that substantially limits one or more major life activities.*
   The condition you listed on your application does not qualify under these definitions.

   b. ☐ The accommodation you are asking for does not qualify under the ADA.
   The requested accommodation (or any other identified accommodation) will not enable you to perform the essential job functions of the position. The ADA defines essential job functions to mean: *the fundamental job duties of the employment position that the individual with a disability holds or desires. The term essential functions does not include marginal functions of the position.*

   You identified you cannot perform the following essential job functions:

   c. ☐ The accommodation as requested would create an undue hardship on the County
   The ADA defines undue hardship as an accommodation which would be unduly costly, expensive, disruptive, or would substantially alter operations.

EMPLOYEE ACCEPTANCE/DECLINATION OF ACCOMMODATION:

☐ I accept the accommodation as offered. Please return by:
☐ I disagree with the determination made with regard to my accommodation and wish to appeal the decision. (Please submit the Appeal Form information to: ADArequests@dutchessny.gov) Please return by:

Employee Signature: _____ Date: _____

NOTE: In addition to the options stated above, if you are not satisfied with the results of this process, you may also:

- file an internal discrimination complaint if you feel the determination is unlawful;
- file a complaint with any compliance agency designated under Sections 503/504 of the Rehabilitation Act of 1973;
- file a complaint with the New York State Division of Human Rights;
- file a complaint with the Equal Employment Opportunity Commission or any appropriate federal oversight agency under the American with Disabilities Act;
- file a private right of action to challenge the alleged discriminatory act, under the New York State Human Rights Law, or any applicable statute.

*You should consult with the appropriate anti-discrimination agency as to the time limitations for initiating such an action.

1. ACCOMMODATION IS BEING GRANTED:

Accommodation Details:
Duration of Accommodation: Permanent ☐ Set Period of Time: ☐ FROM: _____ TO:_____ Frequency of Accommodation: _____

2. REQUESTED ACCOMMODATION CANNOT BE GRANTED; ALTERNATIVE OPTIONS OFFERED

The department is not able to grant your accommodation as requested and is offering the following alternatives to reach a mutually agreeable solution:
Alternative Accommodation Details:

Completed by:_____ Date:_____

Additional Information:

County of Dutchess Department of Human Resources 22 Market Street Poughkeepsie, NY 12601	**MEDICAL PROVIDER FORM TO SUPPORT EMPLOYEE REQUEST FOR ACCOMMODATION PURSUANT TO ADA**

Employee's Name:	
Employee's Job Title:	

The above employee has requested an accommodation under the Americans with Disabilities Act (ADA). In order to evaluate the request, please provide the requested information below.

A. Does the employee have an ADA qualified disability?

For reasonable accommodation under the ADA, an employee **has a disability if he or she has an impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.** Under the 2008 Amended Act the term "substantially limits" is not meant to be a demanding standard. It should be construed liberally and broadly in favor of expansive coverage.

In your opinion, does the employee have a physical or mental impairment within the definition above, and as contained in the ADA or New York State Human Rights Law?	Yes ☐	No ☐ (go no further and sign form on back)

What is the restriction/limitations the employee experiences because of this disability?

How does the restriction/limitations impede the employee's ability to perform their essential job functions?

What is the expected duration of the disability?

☐ Permanent ☐ Expected to last _____ months.

☐ Intermittent ☐ Unknown at this time

Comments on duration:

B. Is an accommodation needed?

An employee is entitled to an accommodation only when an impairment created by the disability affects their ability to perform their **essential job duties** (see attached job description) or to enjoy equal benefits and privileges of employment as enjoyed by other similarly situated employees without disability. The following questions help to determine whether a requested accommodation is needed because of the employee's disability.

Answer the following questions based on the employee's limitations when his or her condition is in an ***active state with no mitigating measures in use***. Mitigating measures would include medications, medical equipment, hearing aids, mobility devices, the use of assistive technology, auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures ***do not include*** ordinary eye glasses or contact lenses.

What functional limitation is interfering with the employee's ability to perform the essential functions of his/her position and/or to enjoy the benefits and privileges of employment? (may list more than one)

How does the employee's functional limitation(s) interfere with his/her ability to perform the job function(s) and/or to enjoy the benefits and privileges of employment?

C. What are the effective accommodation options?

If an employee has a disability and needs an accommodation to perform their job because of the disability, the employer must provide a reasonable accommodation unless that accommodation would pose an undue hardship. The following questions will help to determine an effective accommodation.

In your opinion, what types of accommodation does the employee need to perform their essential job functions and /or to enjoy the benefits and privileges of employment?

Are you aware of any organizations, services, or products that are available in this area?

How will this accommodation address the limitation/disability and allow the employee to perform the essential functions of their job?

D. Other comments and signature

Please include any other comments concerning accommodation for this employee:

Medical Professional's Signature:	
Medical Professional's Printed Name:	
License Number:	
Date:	

AUTHORIZATION FOR LIMITED RELEASE OF MEDICAL INFORMATION

I, _____, authorize the designated health care professional(s) to release medical records and/or discuss with a designee for reasonable accommodation my request for a reasonable accommodation to DUTCHESS COUNTY under the ADA Policy:

Please provide information on all providers related to the requested accommodation.

NAME	ADDRESS	PHONE

DUTCHESS COUNTY will use this information to:

- ✓ Confirm that my medical condition is a disability under the Americans with Disabilities Act, as amended;
- ✓ Confirm the functional limitation(s) or work related restrictions are associated with the stated disability;
- ✓ Confirm why the requested reasonable accommodation is needed;
- ✓ Obtain clarification of any medical information previously submitted to Dutchess County;
- ✓ Seek recommendations regarding alternative accommodations.

I understand that the information that is collected and discussed is to be treated with confidentiality and will not be shared with co-workers. However, directly relevant information may be shared with supervisors/managers; with those responsible for emergency treatment; and the ADA Review Committee to make decisions or provide advice on matters relating to my request for reasonable accommodation.

This release terminates 90 days after the date of the signature below.

_____ _____

Employee/Applicant Signature *Date*

_____ (_____) _____

Witness Signature *(Printed Name)* *Date*

APPEAL FORM
REQUEST FOR ACCOMMODATION
Americans with Disabilities Act (ADA)

TO: Appeals Officer

Employee/Applicant: _____

Department: _____ Title/Position: _____

Accommodation Request Dated: _____

I hereby appeal the determination related to my request for accommodation under the ADA because:

☐ The accommodation granted is not acceptable. (Complete Section 1)

☐ The accommodation was not granted. (Complete Section 2)

☐ Other: (Complete Section 3)

SECTION I:

The employer offered options for accommodation are not acceptable for the reason described below:

SECTION II

The accommodation as requested should be granted because (select reason and provide details):

☐ It is a qualifying disability under the federal requirements of the ADA because:

☐ The accommodation requested does qualify under the ADA because

☐ The accommodation as requested would not cause an undue hardship because

SECTION III

Other:
Please provide additional details:

Signature: _____ Date: _____

NOTE: Pursuant to the ADA Policy, the employee or applicant shall have the opportunity to appeal a decision of the ADA Committee regarding a reasonable accommodation by submitting a written appeal to the Department of Human Resources using the Appeal Form (#5). The appeal should include an explanation as to why the accommodation offered is not appropriate or why the accommodation should be granted. The Department of Human Resources shall investigate the complaint on appeal and make a recommendation to the County Executive's designee. The County Executive's designee will make the decision on appeal. The County Executive's designee on appeal must not have participated as a member of the ADA Committee upon initial review.