[INSERT ORGANIZATION NAME]

Employee Disability Accommodation Policy

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| --- | --- |
| [INSERT ORGANIZATION NAME]Employee Disability Accommodation Policy | Approved by the Board of Trustees:DRAFT FOR REVIEW |
| Position(s) responsible for Compliance:  Executive Director, Board | To be reviewed: Annually |

**Policy**

The Americans with Disabilities Act ("ADA") and New York Human Rights Law ("HRL") require that people with disabilities not be denied the right to work when accommodations would not impose an undue hardship on the employer.

In furtherance of its mission and to provide an inclusive work environment, the [INSERT NAME] uses the ADA and the HRL to guide policy and procedure regarding disability accommodations and employment.

To ensure the System's actions reflect this commitment, employees shall follow the below procedures.

**Procedures**

1. Job Notices

All job notices shall include notice as to how an applicant may request ADA accommodations to apply and/or interview for a job at the [ORGANIZATION].

2. Applicants

No pre-employment inquiries (e.g., on an employee application or in an employment interview) will be made into an applicant’s disability, into the nature or severity of an applicant’s disability, or into prior workers’ compensation claims that an applicant may have filed.

Consistent with current law, regulations, and guidance, applicants may be asked about their ability to perform job-related functions and/or to describe or demonstrate how, with or without reasonable accommodation, the applicant will be able to perform job-related functions.

3. Procurement of workplace equipment

Within established budgets, all procurement efforts shall include consideration of accessibility and universal design.

4. Requesting accommodations

Reasonable accommodation is available to an employee with a disability when the disability affects the performance of job functions.

Employees may initiate a request for disability accommodations by contacting their supervisor or the Executive Director and filling out the form attached to this policy as "A". The System will attempt to reasonably accommodate qualified individuals with a temporary or long-term disability so that they can perform the essential functions of the job, unless doing so would create an undue hardship for the operations of the [ORGANIZATION].

Accommodations will be confirmed or denied in a letter. A denial of accommodations may be appealed per number 6, below.

The [ORGANIZATION] refers to resources such as ASKJAN.ORG to be proactive about access to particular resources and to develop responses to reasonable accommodation requests.

5. Coordination with other policies

[ORGANIZATION] employees are able to coordinate use of sick leave, family medical leave, disability leave, and other types of leave with disability accommodations, but such types of leave are additive and shall not be a substitute for ongoing disability accommodations if such reasonable accommodations are granted.

6. Reporting Concerns

Any individual who believes that they have been denied an accommodation in error or discriminated against on the basis of having, or being perceived to have, a disability, or believes they have witnessed such discrimination by the [ORGANIZATION], is encouraged to report their concerns to their supervisor, or the Executive Director, or a member of the Executive Committee of the Board of Trustees, who shall create a record of such report, ensure it is investigated to the degree warranted, and that any necessary remedial actions are taken.

Forms:

* [Accommodation Approval Form](https://askjan.org/Forms/upload/accommodationapprovalform.doc)
* [Onboarding Form](https://askjan.org/Forms/upload/onboardingform.doc)
* [Monitoring Form](https://askjan.org/Forms/upload/MonitoringRASampleForm.doc)
* [Denial Form](https://askjan.org/Forms/upload/accommodationdenialform.doc)
* [Appeals Form](https://askjan.org/topics/upload/raappeal.doc)

**[INSERT ORGANIZATION NAME]** **ACCOMMODATION APPROVAL FORM**

|  |  |
| --- | --- |
| Employee Name: | Date of Approval: |
| Accommodation(s) Approved: |
|  |
| **STEPS NEEDED TO IMPLEMENT** |
|  | Yes 🞎 | No 🞎 |
| Does equipment need to be ordered or a service purchased?  |
|  |
|  |
| If *yes*, who will do it? |  |
|  |
|  | Yes 🞎 | No 🞎 |
| Will training be required? |
|  |
|  |
| If *yes,* who will do the training? |
| Who needs to be notified of the accommodation?  |
| What other steps need to be taken? |
|  |
| **TIMEFRAMES** |
| When will the accommodation be fully implemented? | Date: |
| If maintenance is needed, when will it be done? | Date: |
| Is the accommodation being provided on a trial basis? | Yes 🞎 | No 🞎 |
| If *yes*, when will the trial period end? | Date: |
| Comments: |
| **SIGNATURES**  |
| Employer Representative:  | Date: |
| Employee:  | Date: |

**[INSERT ORGANIZATION NAME]** **ONBOARDING REASONABLE ACCOMMODATION REQUEST FORM FOR NEW EMPLOYEES**

|  |
| --- |
| **A. Questions to clarify accommodation requested.** |
| What specific accommodation are you requesting?🞎 Access to Website and online forms🞎 Print material in an accessible format including providing media in alternative format as needed (large print, Braille, text file, etc.) 🞎 Accessible parking and building access (keyless entry, security issues, restrooms, break rooms, exercise rooms, etc.)🞎 Use of service animal in the workplace 🞎 Computer and communication technology access (alternative input devices, screen reading software, screen magnification, telephone amplification, smartphone or tablet apps, etc.)🞎 Workspace modifications (furniture, lighting, space, noise abatement, etc.) 🞎 Services or work-related assistance (sign language interpreters, readers, note takers, etc.)🞎 Emergency evacuation and shelter-in-place plan needs🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞎 Not sure what accommodation is needed. |
| Please explain.  |
| **B. Questions to document the reason for accommodation request.** |
| What, if any, job function do you expect to have difficulty performing? |
| What, if any, employment benefit do you expect to have difficulty accessing? |
| What limitation do you anticipate interfering with your ability to perform your job or access an employment benefit? |
| Have you had any accommodations in the past for this same limitation?  |  Yes 🞎 | No 🞎 |
| If *yes*, what were they and how effective were they? |
| If you are requesting a specific accommodation, how will that accommodation assist you?  |
| **C. Other.**Please provide any additional information that might be useful in processing your accommodation request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature DateReturn this form to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

**[INSERT ORGANIZATION NAME] FORM FOR** **MONITORING ACCOMMODATIONS**

|  |
| --- |
| 1. **DOCUMENTING CURRENT ACCOMMODATIONS**
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| What accommodations have been implemented to enable the employee to perform essential job duties or enjoy equal benefits or privileges?When were the current accommodations implemented (month, day, year), and who was responsible for implementation?What is the cost, if any, of providing the current accommodations? One-time cost or on-going? What department or agency is responsible for the cost? |
| 1. **EVALUATING CURRENT ACCOMMODATIONS FOR EFFECTIVENESS**
 |
| The accommodations are in effect:* Always
* As-needed
* Never

For example, employee works from home as-needed, has a flexible schedule three days per week, or uses assistive technology daily. If frequency is not clearly defined here or employee indicates *Never*, please explain: If equipment or software was provided, was the employee trained in the use of that equipment or software?* Yes
* No

Does the employee report that the training was sufficient to meet his/her needs?* Yes
* No

If no, explain:If a service (e.g., interpreter, reader, CART) was provided, does the employee report that the service is meeting his/her needs? Who is responsible for arranging the service?If workstation equipment was provided, is it being used effectively and properly? Explain any issues in using workstation equipment.Are the accommodations currently enabling the employee to perform essential job functions? Explain.*If* *applicable*, explain how accommodations have enabled the employee to improve his/her performance/conduct.What difficulties, if any, does the employee experience when engaging accommodations (i.e., equipment does not work, scheduling needs not met, harassed by management, etc.)?Is the employee currently requesting additional or alternative accommodations?* Yes
* No

If yes:* What job function(s) is s/he having difficulty performing?
* What employment benefit(s) is s/he having difficulty accessing?
* What limitation(s) is/are interfering with his/her ability to perform the job or access an employment benefit?

Explain what new accommodations are being requested and how the employee, or his/her representative, believes the accommodations will assist the employee. Describe the *employee’s perception* of how well accommodations have worked. |
| 1. **RECOMMENDATIONS**
 |
| Current accommodations have been found to:* Be effective for the purpose
* Require adjustments
* Be ineffective for the purpose
* Require additional accommodations to be effective

Explain. The employee should:* Maintain accommodations “as is”
* Continue with current accommodations but with adjustments
* Discontinue current accommodations
* Receive alternative accommodations

Explain.If new or additional accommodations are required:Does equipment need to be ordered or a service purchased? * Yes
* No

If yes, who will order, etc.? Will training be required? * Yes
* No

If yes, who will provide the training?Who should be notified of any change in accommodations (i.e., manager, HR, DPM, etc.)? Do any additional steps need to be taken?When will accommodations be fully implemented?Date:If maintenance is required, when will it occur?Date:Are accommodations being provided on a trial basis?* Yes
* No

If yes, when will the trial period end?Date: |
| SIGNATURES Employer Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**[INSERT ORGANIZATION NAME] ACCOMMODATION DENIAL FORM**

|  |  |
| --- | --- |
| Employee Name: | Date of Denial: |
| Accommodation(s) Denied: |
|  |
| **REASON(S) FOR DENIAL** (may check more than one box) |
| 🞎 Accommodation Ineffective 🞎 Accommodation Would Cause Undue Hardship🞎 Medical Documentation Inadequate🞎 Accommodation Would Require Removal of an Essential Function🞎 Accommodation Would Require Lowering of Performance or Production Standard🞎 Other:  |
| **DETAILED REASON(S) FOR THE DENIAL OF ACCOMMODATION** |
|  |
| **NEXT STEPS** |
| 🞎 Provide Additional Information🞎 Meet to Discuss Other Accommodation Options🞎 Explore Reassignment🞎 Terminate Employment  | 🞎 Other:  |
| **COMMENTS** |
| **SIGNATURES** |
| Employer Representative:  | Date: |
| Employee:  | Date: |

**[INSERT ORGANIZATION NAME] APPEAL OF A REASONABLE ACCOMMODATION DETERMINATION**

This form is to be used by a [INSERT ORGANIZATION NAME] employee or applicant who wishes to appeal the determination of a request for reasonable accommodation.

**All** **appeals must be received by the Accommodation Specialist or other designated individual within thirty (30) days of the date of notification of the initial determination.**

**Please submit a copy of your appeal to NAME/TITLE** at EMAIL ADDRESS.

**INSTRUCTIONS:** The employee/applicant should complete Section I of this form and forward it to the above-named person in an envelope marked "Confidential.”

**SECTION I – TO BE COMPLETED BY EMPLOYEE / APPLICANT**

Name:

Type of Accommodation Requested:

Date of Reasonable Accommodation Determination:

Statement of Appeal (clearly state all grounds for appeal; attach additional sheets as necessary):

I am attaching the following additional documentation (do not resubmit any documentation):

I affirm that I have reviewed this accommodation appeal and that it is true to the best of my knowledge, information and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Employee / Applicant

**SECTION II – FOR INTERNAL USE**

Date Appeal Received:

Date of Acknowledgement:

Disposition of Appeal:

Date of Notification of Disposition: