

DANIEL D. MILLERDEPUTY EXECUTIVE DIRECTOR

Reasonable Accommodation Request Form

March 2022

TO: All BERS Employees

FROM: Sanford Rich

Executive Director

SUBJECT: REASONABLE ACCOMMODATION REQUEST

It is the policy of the NYC Board of Education Retirement System (BERS) to provide reasonable accommodations to employees that permit them to perform the essential functions of the job in connection with disability, religion, pregnancy, childbirth or a related condition, and status as a victim of domestic violence, sex offenses, or stalking (collectively "protected bases")*, unless so doing will result in undue hardship to the agency. BERS is also committed to providing reasonable accommodations that enable employees with disabilities to enjoy equal benefits and privileges of employment as are enjoyed by similarly situated employees without disabilities.

Any current or prospective employee who is a qualified individual may request a reasonable accommodation in order to assist in performing the essential functions of his/her present assignment. Determinations regarding accommodations will be made on an individual basis after a review of the following: the individual's functional limitations; the medical documentation of the individual (if applicable), the essential functions of the job; and whether the granting of the accommodation would impose an undue hardship on BERS. Information regarding an individual's disability will be kept confidential to the extent required by law.

REQUESTING AN ACCOMMODATION

As a first step, an individual who feels that he/she is in need of an accommodation must first discuss the request informally with his/her supervisor. An individual is not required to provide information as to the nature of his/her disability, and need only state the need for an accommodation, and outline his/her functional limitations and the particular accommodation(s) requested.

Examples of such accommodations include, but are not limited to: visual aid equipment, ergonomic chair, telework schedule (due to an underlying health condition), and modified or flexible work schedules. If an accommodation request is denied or cannot be provided through the above-referenced informal means, the individual may apply for a formal accommodation by submitting the Accommodation Request Form on pages #3 and #4. Medical or other documentation to support the request must be attached.

The request is to be forwarded to the **Principal EEO Officer**, **Michelle Pyram**, at mpyram@bers.nyc.gov, with a copy to the **Deputy EEO Professional**, **Lydia Ahmim**, at lahmim@bers.nyc.gov.



TIMEFRAME FOR PROCESSING ACCOMMODATION REQUESTS

Informal

The individual should speak to his/her supervisor regarding the accommodation need to determine if granting it would cause undue hardship to the agency. In the case of an informal request, the supervisor can decide if the request would need to be escalated to a formal review. An informal request will be granted or denied within 10 business days.

Formal

If all the supporting information requested has been provided, all accommodation requests will be either granted or denied within 30 days of making the request. The decision will be communicated directly to the individual, with a copy to their immediate supervisor.

Expedited

If an accommodation is needed for imminent medical treatment or to avoid imminent emotional and/or bodily harm, the individuals should submit a request for reasonable accommodation for expedited review. Requests of this nature will be reviewed and decided on in less than 30 days.

GRANTING AN ACCOMMODATION

The Principal EEO Officer will review each request carefully and take into consideration that there is no "one-size-fits-all" formula for deciding when to grant a reasonable accommodation. During the review, the Principal EEO Officer will meet with the individual to determine physical or mental abilities or limitations and the specific barriers these limitations pose to the performance of the job's essential functions. If a reasonable accommodation is possible, the Principal EEO Officer will forward the details of the accommodation to the individual's supervisor and the Executive Office. Once granted, accommodations may be reevaluated, modified or terminated due to changed circumstances.

NOTIFICATION OF A DETERMINATION

When a final determination to either approve or deny an accommodation request has been rendered, an official letter will be sent to the individual via email and regular mail. A copy of the final determination letter will be placed in the individual's file and also forwarded to the individual's supervisor. Reasonable accommodations will also be reported in DCAS' Citywide Complaint/Reasonable Accommodation Tracking System.

*Please note: A request for remote work to care for another individual (e.g. your child or a member of your household with an underlying health condition, etc.) is not currently covered under this Reasonable Accommodations Policy. Please speak with your immediate supervisor to discuss leave options or possible alternative work arrangements.



A. Reasonable Accommodation Request Form

This form and all information must be kept confidential.

NAME AND CONTACT INFORMATION				
Print full name		☐ Current empl	loyee	
		☐ Job applican		
		☐ Other (please specify)		
Home or work address:		Phone number		
EMPLOYEE INFORMATION (Cor	mplete this secti	on only if you are	an employee)	
Civil service title		Office title		
Office telephone number		Email address	Email address	
•				
Supervisor name	Phone number		Supervisor email address	
Capar risor manie			Cupo. 11001 omaii adai 000	
Division		Worksite/location	n	
APPLICANT INFORMATION (Co	mplete this secti	on only if you are	e a job applicant)	
Position/title sought		Division/unit (if I	known)	
1 Osition/title sought		Division/unit (if known)		
Location of position (if known)				
Part(s) of the employment proce	ess for which an	accommodation i	s requested (please check the	
box below): ☐ Job application				
Job vacancy notice number (if k	nown):			
□ Interview	,			
Interview date:				
☐ Other (please specify):				
			Black	
Agency contact person (if known)			Phone number	



Basis of reasonable accommod	dation request:	
☐ Disability		
☐ Religion	f demonstic violence any efference on etallicina	
	of domestic violence, sex offenses, or stalking or a related medical condition	
	ortn, or a related medical condition	
Lacta	uion neeus	
Is the condition for which you a	are requesting an accommodation:	
☐ Permanent	☐ Temporary ☐ Unknown	
If temporary, anticipated date accommodation(s) no longer needed:		
accommodation requested and essential functions of the positi	res accommodation and describe the nature of reasonable how the accommodation will assist you to perform the tion held or desired, or to enjoy the benefits and privileges of c. (Attach additional sheets and present supporting)	
If equipment is requested, plea	se specify brand, model number and vendor, if known.	
For reasonable accommodation provide additional medical docu	requests based on disability, you may be asked to umentation to better assess your need.	
	FIDENTIAL documentation should be provided isabilities Rights Coordinator or EEO officer	
Such documentation should:		
	by the health professional (e.g. M.D. D.O. etc.)	
☐ Be dated and signed by the health professional. (e.g., M.D., D.O., etc.)		
☐ Describe the severity of the disability and its limitations in detail as they currently exist and how they limit the individual's ability to perform the essential functions of the job.		
	which the accommodation will permit you to perform the	
	the job or to enjoy the benefits and privileges of employment.	
	ation of disability is permanent or temporary or unknown.	
	the date the disability is expected to no longer require	
accommodation.		
I certify that I have read and understood the information provided in this request, and that it is true to the best of my knowledge, information, and belief.		
Date	Requestor's signature/authorized agent	



B. Authorization for Release of Health Information Pursuant to HIPAA



OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA [This form has been approved by the New York State Department of Health]

Patient Name Date of Birth Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-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.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

CARE WITH ANYONE OTHER THAN THE ATTORNEY OF		
7. Name and address of health provider or entity to release this information:		
8. Name and address of person(s) or category of person to whom th	is information will be sent:	
9(a). Specific information to be released:		
☐ Medical Record from (insert date)	to (insert date)otes (except psychotherapy notes), test results, radiology studies, films,	
☐ Entire Medical Record, including patient histories, office no referrals, consults, billing records, insurance records, and re	otes (except psychotherapy notes), test results, radiology studies, films, ecords sent to you by other health care providers.	
☐ Other: Include: (Indicate by Initialing)		
	Alcohol/Drug Treatment	
	Mental Health Information	
Authorization to Discuss Health Information	HIV-Related Information	
(b) □ By initialing here I authorize		
(b) By initialing here I authorize	Name of individual health care provider	
to discuss my health information with my attorney, or a governmental agency, listed here:		
(Attorney/Firm Name or Gov		
10. Reason for release of information:	11. Date or event on which this authorization will expire:	
☐ At request of individual		
☐ Other:		
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:	
All items on this form have been completed and my questions abou copy of the form.	t this form have been answered. In addition, I have been provided a	

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Signature of patient or representative authorized by law.



C. Reasonable Accommodation Request Record of Steps and Outcome

REASONABLE ACCOMMODATION REQUEST RECORD OF STEPS AND OUTCOME			
Name of applicant/employee:	Telephone number:		
Address:			
Request number:	Received by:		
Date received:	Received by:		
Method of filing:	I		
☐ In Person ☐ Phone ☐ Mail ☐ E-mail			
DOCUMENTATION OF STEPS TAKEN TO CONSIDER REQUEST			
DOCUMENTATION OF STEPS T	AKEN TO CONSIDER REQUEST		
DOCUMENTATION OF STEPS T	AKEN TO CONSIDER REQUEST COMMENTS:		



RESOL	LUTION
☐ Granted	Type of accommodation granted:
	☐ As requested
Date:	☐ Different from what was requested
	Please provide specifics: (Attach additional sheets as needed.)
☐ Denied	Reason for denial:
Date:	
Date when letter granting or denying the requested a	accommodation was sent to employee or applicant:
Signature	Date:



D. Granting of Reasonable Accommodation Request

GRANTING OF REASONABLE ACCOMMODATION REQUEST	
(To be completed by deciding official)	
1. Full name of individual requesting reasonable accommodation:	
2. Basis for reasonable accommodation request:	
☐ Disability	
☐ Status as victim of domestic violence, sex offenses, or stalking	
☐ Pregnancy, childbirth or a related medical condition	
☐ Lactation needs	
3. Specific accommodation requested:	
4. Decision:	
☐ Reasonable accommodation granted as requested	
☐ Alternative accommodation granted	
Describe accommodation granted:	
Describe accommodation granted.	
Deciding official name (print):	
Signature:	
Date granted:	
Telephone:	
Email:	
cc: EEO officer, and if applicable, agency personnel officer, manager/supervisor.	



E. Denial of Reasonable Accommodation Request

	DENIAL OF REASONABLE ACCOMMODATION REQUEST
	(To be completed by deciding official)
1.	Name of individual requesting reasonable accommodation:
2	Davis for many allegations and delication and actions are sententially
۷.	Basis for reasonable accommodation request:
	☐ Disability
	□ Religion
	☐ Status as victim of domestic violence, sex offenses, or stalking
	☐ Pregnancy, childbirth, or a related medical condition
	☐ Lactation needs
3.	Specific accommodation request:
4.	Request for reasonable accommodation denied because (you may check more than one box).
	☐ Employee's request determined not to be related to a disability
	☐ Employee's request determined not to be related to religion
	☐ Employee determined not to be a victim of domestic violence, sex offenses, or
	stalking
	☐ Employee's request determined not to be related to pregnancy, childbirth, or related medical condition
	☐ Employee's request determined not to be related to a lactation need
	☐ Accommodation would not meet requested need
	☐ Accommodation would cause undue hardship
	☐ Documentation of need for the accommodation inadequate
	☐ Accommodation would require removal of an essential function of the job
	☐ Accommodation would pose direct threat
	☐ Other (please specify)



5. Reason(s) for the denial of reasonable accommodation (must be specific, e.g., why accommodation is ineffective or causes undue hardship).	
6. If the individual proposed one type of reasonable accommodation, which is being denied, but rejected an offer of a different type of reasonable accommodation, explain both the reasons for denial of the requested accommodation and reason why chosen accommodation would be effective.	
7. Appeal: Where an employee or applicant has requested a reasonable accommodation consistent with these procedures and the agency representative has not provided the reasonable accommodation, an appeal may be made to the agency head or their designee within 10 days from when the EEO Office issues the decision.	
8. If a job applicant or employee wishes to file an internal EEO complaint, they must contact (name), the agency EEO officer (provide contact information).	
Deciding official	
Name (print):	
Telephone:	
Email:	
Signature: Date denied	
cc: EEO officer, and if applicable, agency personnel officer, manager/supervisor.	