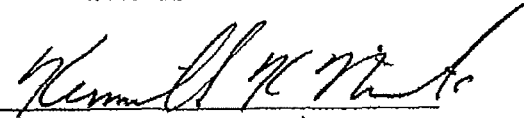



CITY OF SACRAMENTO
ADMINISTRATIVE POLICY INSTRUCTION

Topic: Reasonable Accommodation Policy
From: Administrative Services Department
To: Department Directors/ Division Managers

Effective Date: 11/30/99
Supersedes: New
Section: API #11



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APPROVED: 

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POLICY

It is the policy of the City of Sacramento not to discriminate on the basis of disability against any qualified person. To this end all decisions relating to employment including, but not limited to recruitment, selection, training, assignment, promotion, compensation, transfer, benefits, and education, will be determined by the applicant's or employee's ability with consideration of any requested reasonable accommodation. This policy is applicable to all employment policies and practices. The City also provides reasonable accommodation in connection with the provision of City services, programs and activities.

A. Definition of reasonable accommodation:

- (1) Reasonable accommodation is an adjustment to job duties, performance methods, and/or work setting or service delivery to meet the individualized need of a individual, applicant or employee with a disability.
- (2) The provision of a reasonable accommodation removes barriers in a specific situation, which prevent or limit the application process, recruitment, employment and upward mobility of a qualified person with a disability or prevents their participation in a program, activity or event.

B. Examples of reasonable accommodation are:

- * Making facilities accessible and usable;
- * Job restructuring;
- * Modifying work schedules;
- * Implementing flexible leave policies;
- * Reassigning to a vacant position;
- * Providing assistive equipment at City programs;
- * Modifying test, training materials and policies; or
- * Providing qualified readers or interpreters.

1. SCOPE AND PURPOSE

- 1.1 Scope: This Administrative Policy Instruction (API) provides guidance and the procedure through which individuals may request reasonable accommodation; and the manner in which departments should consider and review those requests.
- 1.2 Purpose: This Administrative Policy Instruction (API) is intended to assist applicants for employment, current employees, individuals desiring to participate in City sponsored programs or activities, and department supervisors and managers in requesting and processing reasonable accommodation requests. It covers the following:

- * Guidelines for filing a Request for Reasonable Accommodation
- * Guidelines for considering and evaluating a Request for Reasonable Accommodation.
- * Appeal process

2. FILING A REQUEST FOR REASONABLE ACCOMMODATION

2.1 Any applicant for employment, current employee, or individual with a disability seeking to participate in a City program or activity, or his/her representative, may request reasonable accommodation. The applicable department shall provide persons requesting accommodation a Reasonable Accommodation Request Form (Attachment 1). It is the responsibility of the requester to complete in full and submit the form to the Director or the department representative responsible for the employment or program activity.

- (a) Individuals seeking, or supervisors wanting to provide informally, a reasonable accommodation may do so; a formal request would follow if the informal request was rejected.
- (b) Although the responsibility for requesting the reasonable accommodation rests primarily with the applicant, employee, or participant the department ADA Coordinator and the City's Affirmative Action Officer are available as resources in the preparation, explanation, and dissemination of reasonable accommodation information or technical assistance.

2.2 All requests for accommodation must indicate the following:

- (a) Name, address, and telephone number of the person requesting accommodation.
- (b) The specific limitation, the type of accommodation requested, with an explanation of how the accommodation will allow the performance of the essential functions of the position or the participation in a program or activity.
- (c) Verification of the disability by the requester's physician, medical provider or vocational/rehabilitation counselor may be required. (If medical verification is required the person requesting accommodation must sign a release form (Attachment 2).

3. REVIEW OF REQUESTS FOR REASONABLE ACCOMMODATION

- 3.1 Because of the personal nature of some disability issues every reasonable effort should be taken to ensure confidentiality during the entire review process.
- (a) The determination whether to provide an accommodation is made on a case-by-case basis. This is an individual process through which the department and the individual with a disability discuss and arrange for the necessary (and reasonable) changes. The department must make a "reasonable effort" to determine the appropriate accommodation. Primary consideration should be given to the preferences of the individual when deciding on accommodation, however, the department has the ultimate discretion to choose between effective accommodations.
 - (b) A department may not compel an individual with a disability to use an accommodation that is not necessary to perform the job.
- 3.2 In considering a request for accommodation a department will complete the Reasonable Accommodation Review Form (Attachment 3). The following factors must be considered when reviewing a request for accommodation:
- (a) Analyze the job or activity to determine the essential functions.
 - (b) Determine with the employee, applicant or participant how the disability limits their performance of the essential functions.
 - (c) Identify accommodation options that overcome limitations and determine the effectiveness and feasibility of the proposed accommodations.
 - (d) Considering the requester's preference, the department selects the accommodation most appropriate for the requester and the department.
- 3.3 If the request is approved, the Director or department representative will notify the requester and make the necessary implementation arrangements. If the request is denied, the requester may appeal to the Affirmative Action Officer within thirty (30) calendar days.
- 3.4 The review process concluding with the approval or denial recommendation, shall be completed in fifteen (15) working days from the date of the request, unless the requester and the department agree to an extension of time.

If a department reviews and approves the request for accommodation, it shall provide the accommodation without undue delay.

4. APPEAL PROCESS

- 4.1 Department decisions on reasonable accommodation may be appealed to the Affirmative Action Officer. The appeal must be submitted within thirty (30) calendar days from the date of notification by the Department. The Affirmative Action Officer shall review the matter and inform all parties of his/her decision. The department will provide all necessary information to facilitate this review.
- 4.2 The decision of the Affirmative Action Officer may be appealed to the City Manager. All appeals must be in writing and submitted within five (5) calendar days of notification of decision by the Affirmative Action Officer. Upon notification, the Affirmative Action Officer shall forward all related documents to the City Manager. The decision of the City Manager is the final internal appeal.



CITY OF SACRAMENTO

REASONABLE ACCOMMODATION REQUEST FORM

PERSONAL INFORMATION NOTICE
Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code Sections 1798, et seq.), notice is hereby given for the request of personal information by this form.

To: _____
(Department Head)

From: _____
(Name of person requesting accommodation)

Address _____
Street Apt. # City State Zip

Telephone () _____

REQUEST FOR REASONABLE ACCOMMODATION

- 1. I am requesting accommodation because (circle one): A or B or C
(A) I am requesting accommodation that will allow me to participate in a City offered program, activity or service. Activity name: _____
(B) I am applying for employment. The accommodation requested will allow me to participate in the examination for (position title): _____
(C) I am currently employed by the City and request a reasonable accommodation. My current job title is: _____

2. My specific functional limitation is: _____ The accommodation I am requesting is described below. (Describe the type of accommodation; if it is a purchasable item list model, number, cost, where it can be obtained, etc., suggestions for work site or examination site modifications or specific job duties which may be restructured or shared to facilitate employment, participate in the examination or utilize a City program, activity or service.)

3. Describe how this accommodation will assist you. © Please attach additional sheets as necessary

EMPLOYEE CERTIFICATION

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the equipment, services, or work adjustments described above.

Signature: _____ (Date)



CITY OF SACRAMENTO
REQUEST FOR MEDICAL INFORMATION FOR
REASONABLE ACCOMMODATION

DATE: _____

TO: _____
 (Physician or Medical Provider)

FROM: _____
 (ADA Coordinator)

SUBJECT: **REQUEST FOR MEDICAL INFORMATION NEEDED TO ASSIST IN PROVIDING A REASONABLE ACCOMMODATION FOR:**

 (Applicant/Employee/Participant)

 (Medical Record #)

 (Social Security #)

The City of Sacramento is attempting to provide reasonable accommodation to the Applicant/Employee/Participant indicated above to assist in providing employment or participation in a program, activity or service. The information requested below is confidential and will only be used to determine the specific equipment and/or services necessary to accommodate the identified limitations due to the verified disability.

Under the Americans with Disabilities Act, an *individual with a disability* is a person who:

- Has a physical or mental impairment that substantially limits one or more major life activities (major life activity may include walking, breathing, speaking, performing manual task, seeing, hearing, learning, caring for oneself, sitting, standing, lifting, or reading);
- Has a record of such an impairment; or
- Is regarded as having such an impairment.

Please take the above definition into consideration and answer the following questions with respect to Applicant/Employee/Participant's request for reasonable accommodation:

1. Does the individual have an impairment that limits a major life activity? YES NO

If yes, please see the reverse side of this form to describe the limitation.

2. Is the disability permanent? YES NO Length of anticipated duration _____

3. From the enclosed job description, specify the job duty that the employee cannot perform _____

4. How does the limitation(s), impair the ability of the Applicant/Employee/Participant to perform the job duty described above?

PHYSICIAN'S SIGNATURE	DATE	PHONE
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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, _____, HEREBY AUTHORIZE _____
(name) (name)

to release to the **City of Sacramento** medical information pertinent to the reasonable accommodation requested in the attached document.

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration: I authorize you to release to the City of Sacramento the above-requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period 180 days after the date of my signature or earlier if revoked by me in writing to the City of Sacramento. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

REDISCLASURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

Employee Signature

Date

**AUTHORIZATION FOR THE RELEASE OF
MEDICAL INFORMATION**

I, _____, HEREBY AUTHORIZE _____
(name) (name)

to release to the **City of Sacramento** medical information pertinent to the reasonable accommodation requested in the attached document.

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration: I authorize you to release to the City of Sacramento the above-requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period 180 days after the date of my signature or earlier if revoked by me in writing to the City of Sacramento. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

REDISCLASURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

Employee Signature

Date



KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

**AUTHORIZATION FOR USE OR DISCLOSURE
OF PATIENT HEALTH INFORMATION**

Note: Fees may apply to certain requests

Patient Name: _____

Kaiser # _____ Date of Birth: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone #: () _____

Email: _____

**Kaiser Permanente will not condition treatment, payment, enrollment or
eligibility for benefits on providing, or refusing to provide this authorization.**

**This authorizes the following Kaiser Permanente
Medical Center(s):** _____

to disclose information as specified below for the
following purpose(s): _____

Kaiser Permanente may disclose this information to:

Check if same as above (disclosure to patient)

Recipient Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone #: () _____ Fax #: () _____

Email: _____

Copies of records or medical record information within the following dates: _____ to _____

Both Hospital and Medical Office Records Medical Office Records Hospital Records

Records limited to a specific provider: _____ or department: _____

X-Ray films X-Ray Digital Images Laboratory Results

**NOTE: Hospital and Medical Office records may include disclosure of information related to mental
health, alcohol/drug, and HIV references contained within those records as part of this authorization.**

**The actual treatment records from mental health, or alcohol/drug departments, or results of HIV
antibody tests are specifically protected, and will not be disclosed unless you sign below.**

Mental Health department records → Signature: _____

Alcohol / Drug dependency treatment records → Signature: _____

HIV antibody test results → Signature: _____

Media Type: Electronic Paper **Delivery Preference:** Email/Secure Portal Mail Pickup

DURATION: This authorization shall remain in effect for one year from the date of signature unless a
different date is specified here _____ (date).

REVOCACTION: You or your representative can revoke this authorization upon written request. If you
revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLASURE: Once this health information is disclosed, how the recipient further discloses it may no
longer be protected under federal privacy law (HIPAA). California recipients are
required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that
provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date

Signature

If not patient, print your name and relationship



CITY OF SACRAMENTO
REASONABLE ACCOMMODATION
REQUEST REVIEW FORM

This form is to be completed in full by the department and returned to the Affirmative Action Officer.

Requester's Name: _____ Date Request Received _____

Currently employed by the City? Yes _____ No _____

Type of functional limitation: _____

Indicate the purpose for requesting accommodation: _____

Describe the accommodation being requested _____

Indicate the essential functions of the job or program/activity: _____

Was a Request for Medical Information Form sent to the applicant's physician/medical provider/vocational/rehabilitation counselor?

No _____ Yes _____

The medical information provided the City was reviewed by (name): _____

Can the person perform the essential functions of the job/program/activity when provided a reasonable accommodation?

No _____ Yes _____

List the accommodation options that overcome the limitations: _____

What steps were taken to determine the effectiveness and feasibility of the proposed accommodations? _____

REQUEST FOR REASONABLE ACCOMMODATION:

GRANTED _____ **DENIED** _____

If granted, indicate what accommodation will be provided. If denied, explain the rationale for this decision.: _____

Date of completion of Request Review: _____

Staff person responding to Reasonable Accommodation Request:

Name: _____ Telephone: _____

Title: _____

Signature: _____

(Dept. Head/Division Manager)