The Community Partnership
For the Prevention of Homelessness

Date: ____

Subject: **CONFIRMATION OF REASONABLE ACCOMMODATION REQUEST**

Dear: ____:

On _____________________________, your service provider ____________________________________ informed me that you are seeking a reasonable accommodation to: ____. This letter serves to confirm that request.

The Community Partnership for the Prevention of Homelessness (TCP) and the Department of Human Services (DHS) is committed to providing reasonable accommodations to its consumers and providers to ensure that individuals with disabilities enjoy equal access to all opportunities. To better respond to your request, we require additional information from your treating physician.

There are several important documents included with this correspondence. They include: (1) Our Reasonable Accommodation Request Confirmation and (2) A Medical Questionnaire.

Please share this entire packet with your care provider and have them to complete the medical questionnaire. Please return the completed questionnaire to me. A response will be provided within 15 days of receipt of the completed questionnaire.

If you have any questions regarding this process, please do not hesitate to contact me. You may call me at __________________________ or by email at _______________________________________.

Sincerely,

____

The Community Partnership
For the Prevention of Homelessness

Date: ____

QUESTIONNAIRE FOR REASONABLE ACCOMMODATION REQUEST

To the Care Provider:

Your patient, ___________________________ indicated that she/he needs ____. We need additional information from his/her treating care provider to properly address this reasonable accommodation request.

Complete this questionnaire relating to your patient. Please type your answers on your official letterhead. This document must also be signed. Documents without a signature or official stamp of the treating professional will not be accepted.

1. State the diagnosis and history of the medical (including psychological, if applicable) condition.

2. State the current status of the condition, including clinical findings from physical and/or mental examination, laboratory tests and other pertinent data.

3. State the patient's prognosis, including plans for future treatment and an estimate of the date of full or partial recovery.

4. State your clinical assessment of risk of injury, or hazard to the patient or others that may arise from the participation in the program or how granting the accommodation will ensure that the patient will receive the same level of services as others in the program.

5. Identify the following major life activities that are affected by the patient's medical condition, if any.

- ☐ Breathing
- ☐ Caring for Self
- ☐ Concentrating
- ☐ Controlling Bowels
- ☐ Eating
- ☐ Hearing
- ☐ Interacting w/Others
- ☐ Learning
- ☐ Lifting

- ☐ Manual Tasks
- ☐ Reaching
- ☐ Reproduction
- ☐ Running
- ☐ Seeing
- ☐ Sexual Function
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking/Mental Health
- ☐ Walking
- ☐ Working

6. Describe what the patient cannot do, as well as what she/he is able to do and compare his/her abilities/limitations of the average person.

7. For each major life activity checked in Number 5 above, please state whether the patient significantly is restricted in his or her ability to perform the activity as compared to the average person and describe how the patient is significantly restricted as compared to the average person for each of the major life activities that applies. For example, if the average person has 20/20 vision but the patient has 240/300 vision, please state how that difference significantly restricts the patient's ability to see as compared to the average person. If the patient is not significantly restricted in any major life activity that you have checked, please so state.

8. How long is the condition expected to last?

9. What accommodations, if any, do you recommend for this patient?

The responses to this questionnaire should be typed on the treating care provider's letterhead and signed by the treating care provider. If the patient has any questions, they may be directed to their service provider or The Community Partnership for the Prevention of Homelessness, Senior Program Officer, Candyce J. Coates, at CCoates@Community-Partnership.org or (202) 543-5298.

The requestor must return the physician's answers to this questionnaire to:

____

Name

____

Address

____

Address Continued

____

Phone

If you disagree with the Reasonable Accommodation Decision, you have the right to Appeal and to file a Complaint

Your Right to Appeal Your Accommodation Request

You can ask for an appeal in any of the following ways:

1. Ask your Program Director to appeal the decision through the **program's internal grievance process**. Each grievance related to a reasonable accommodation request will be brought to the Community Partnership's attention for further review.

2. Within 60 days of the Reasonable Accommodation Decision, **contact the DC Department of Human Services (DHS) ADA Coordinator** at 202-671-4422 phone, 202-671-0180 fax, 202-671-4495 TTY to file an appeal with DHS.

3. Within 90 days of the Reasonable Accommodation Decision, call **the DC Office of Administrative Hearings** (OAH), at 727-8280 or send in your request in writing to the Office of Administrative Hearings, 441 4th Street, N.W., Suite 540 South, Washington, D.C. 20001. *(You can also tell a staff member where you reside that you want a Fair Hearing and he or she must help you make your request or you can call the Family Services Administration, at 541-3914.)*

   OAH will schedule you for an administrative review with DHS. If that hearing doesn't resolve your concerns, you will get a fair hearing with OAH. At your administrative review or hearing, you have the right to be represented by a lawyer (see below), relative, or any other person of your choice who is not an employee of the D.C. Government and to bring witnesses or evidence that helps your case.

Your Right to File a Complaint

If you believe that your rights have been ignored or violated or that you have been discriminated against, you have the right to file a complaint with DC government agencies or in court.

You can file a complaint in any of the following ways:

1. Within 60 days of the decision, **contact the DC Department of Human Services (DHS) ADA Coordinator** at 202-671-4422 phone, 202-671-0180 fax, 202-671-4495 TTY to file a complaint of disability discrimination or violation of disability rights.

2. **Mail a complaint to the Department of Justice**, 950 Pennsylvania Avenue, NW, Civil Rights Division, Disability Rights Section-NYA, Washington, DC 20530.

3. **Call the D.C. Office of Human Rights** at 202-727-4557 phone 202-727-4559, 202-727-8673 TTY. They will interview you to investigate and process your complaint.

4. **File a lawsuit** in D.C. Superior Court or federal court. You may want to seek legal advice if you decide to file a lawsuit (see below). See below for free legal representation.

How to Get Help Appealing or Filing a Complaint

To help you understand your rights and to represent you in appeals or complaints, free lawyers may be available from:

- *The Washington Legal Clinic for the Homeless at (202) 328-5500*
- *Legal Aid Society of the District of Columbia at (202) 628-1161*
- *Bread for the City at (202) 265-2400 OR (202) 561-8587*