

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

REQUEST FOR REASONABLE ACCOMMODATIONS FOR INMATES WITH SENSORIAL DISABILITIES

Date _____

Inmate's Name _____ DIN _____ Facility _____

- I do not request reasonable accommodations
- I request reasonable accommodations as indicated below for the following program or service: _____

Check to indicate request

HEARING IMPAIRMENT		VISUAL IMPAIRMENT	
Requested	Approved	Requested	Approved
<input type="checkbox"/> Qualified Sign Lang. Interpreter	<input type="checkbox"/>	<input type="checkbox"/> Large Print	<input type="checkbox"/>
<input type="checkbox"/> TTD/TTY	<input type="checkbox"/>	<input type="checkbox"/> Orientation & Mobility Instruct	<input type="checkbox"/>
<input type="checkbox"/> Telephone Amplifier	<input type="checkbox"/>	<input type="checkbox"/> Mobility Assistants/Sighted Guide	<input type="checkbox"/>
<input type="checkbox"/> Closed Caption Television	<input type="checkbox"/>	<input type="checkbox"/> Guidance Cane	<input type="checkbox"/>
<input type="checkbox"/> Sound Amplification Systems	<input type="checkbox"/>	<input type="checkbox"/> Support Cane	<input type="checkbox"/>
<input type="checkbox"/> Hearing Aids/Batteries	<input type="checkbox"/>	<input type="checkbox"/> Braille Print	<input type="checkbox"/>
<input type="checkbox"/> Notification Systems	<input type="checkbox"/>	<input type="checkbox"/> Braille Equipment	<input type="checkbox"/>
<input type="checkbox"/> Visual Smoke Detector	<input type="checkbox"/>	<input type="checkbox"/> Magnifiers	<input type="checkbox"/>
<input type="checkbox"/> Preferred Seating	<input type="checkbox"/>	<input type="checkbox"/> Tape Player/Cassettes	<input type="checkbox"/>
<input type="checkbox"/> Shake Awake Alarm	<input type="checkbox"/>	<input type="checkbox"/> Lamp	<input type="checkbox"/>
<input type="checkbox"/> Pocket Talker	<input type="checkbox"/>	<input type="checkbox"/> Visor/Sunglasses for indoor use	<input type="checkbox"/>
		<input type="checkbox"/> Other _____	<input type="checkbox"/>

(Inmate's Signature)

(Staff Name/Title)

(Staff Signature)

MEDICAL VERIFICATION (Use established definitions)

- Severe Visual Impairment (V230) Legally Blind (B240) Non Significant Hearing Loss (HL30)
- Hard of Hearing (HL20) Deaf (HL10)
- No Medical Verification on File Follow-up Appointment Necessary? Yes No

(Medical Staff - Name/Title)

(Med. Staff Signature)

(Date)

Return this form to the Staff member whose name appears next to the inmate's signature above.

REASONABLE ACCOMMODATION DETERMINATION

The reasonable accommodations requested above have been:

- Approved as requested
- Modified - accommodations which have been approved are marked above
- Denied
- Pending medical verification

EXPLANATION of modification or denial: _____

(DSP or designee)

(Signature)

(Date)

This section is to be completed by the inmate.

- I agree I disagree with this determination
- I want to meet with the Superintendent or designee during this review.
- I want to have an interpreter with me or other assistive device during this meeting.

(Inmate's Signature)

(Date)

SUPERINTENDENT'S REVIEW (Superintendent's designee may conduct this review)

Date Received _____ Date of meeting with inmate (if necessary) _____

Your request for reasonable accommodation has been

- Approved as requested
- Modified
- Denied

Explanation: _____

Was sign language interpreter used at meeting Yes No? to interpret decision Yes No?

If not, explain why not _____

 Signature of Superintendent or designee Date

This section is to be completed by the inmate.

- I have been advised of my right to grieve this decision via the Inmate Grievance Program.

Signature of inmate Date