

Request for an Appeal of a Reasonable Accommodation Determination

INSTRUCTIONS:

Complete and submit this form within twenty (20) calendar days from the date on the determination form(s) to:
ADA Compliance Unit
180 Water Street, 17th Floor
New York, New York 10038
Fax: (917) 639-0333
E-mail: adaola@hra.nyc.gov

Appeals should be submitted in writing. You may attach any supporting medical documentation to this form. Individuals who cannot complete written forms due to physical and/or mental condition(s) may contact the Office of Constituent Services (OCS) for assistance at **(212) 331-4640**.

Section I – HRA Client Information:

Name (*Please Print Clearly*): _____ Case Number (*If Known*): _____
Social Security Number (*If Known*): _____ Telephone Number: _____
Mailing Address: _____
HRA Program/Service (*If Known*): _____ Center No. (*If Known*): _____

Section II – Reasonable Accommodation(s) You Wish to Appeal:

You may use this form to appeal more than one determination.

1) Please describe the reasonable accommodation(s) that were denied and the date of denial. (You may attach additional sheets, if necessary.)

2) Please tell us why you think HRA's decision was wrong: _____

3) Were you offered an alternative accommodation? If so, explain here:

If you were offered an alternative accommodation, please indicate by checking the appropriate box below, whether you will accept that alternative accommodation.

- Yes, I will accept the alternative accommodation.
- No, I will not accept the alternative accommodation. Please explain why: _____

HRA Applicant/Participant Signature: _____ Date: _____

-or-

Authorized Representative Signature: _____ Date: _____

Print Name: _____ Relationship to Applicant/Participant: _____

For internal use only: Completed by Office of Constituent Services: _____ Date: _____