Warren County Board of Supervisors

RESOLUTION NO. 280 OF 2017

RESOLUTION INTRODUCED BY SUPERVISORS SEEBER, FRASIER, MCDEVITT, BROCK, VANSELOW, MONTESI, LEGGETT, BRAYMER, GERAGHTY, SIMPSON AND HYDE

APPROVING REVISIONS TO THE AMERICANS WITH DISABILITIES ACT (ADA) SECTION 504 COMPLIANCE POLICY FOR WARREN COUNTY TO ADD A SECTION FOR EMPLOYEE ACCOMMODATION REQUESTS AND TO ESTABLISH A BUDGET CODE FOR SAME

WHEREAS, pursuant to Resolution No. 356 of 2013, the Warren County Board of Supervisors adopted the Americans With Disabilities Act (ADA) Section 504 Compliance Policy to apply to all Warren County buildings, programs, services, activities and County employment and contracts, and

WHEREAS, the policy was subsequently amended by Resolution No. 365 of 2014, and

WHEREAS, the Human Resources Director and the Self-Insurance Administrator have recommended further revisions to the Policy to add a section regarding employee accommodation requests and to establish a budget code for expenses relating to said accommodation requests, now, therefore, be it

RESOLVED, that the Warren County Board of Supervisors hereby approves the revisions to the ADA Section 504 Compliance Policy for Warren County as outlined on the attached Appendix "A", and be it further

RESOLVED, that expenses related to fulfilling said accommodation requests shall be paid from Budget Code A.1435 439 Human Resources, Misc. Fees & Expenses.

APPENDIX A

ACCOMMODATION REQUEST FORM

Amendment to Section VI of the ADA/Section 504 policy adopted by Resolution No. 365 of 2014:

VI. REASONABLE ACCOMODATION PROCEDURES

Any individual who wishes to request a specific accommodation (including communication aids or services) in order to facilitate the delivery of services or participation in programs or activities provided by Warren County should contact the ADA Coordinator as soon as possible but no later than 48 hours before the scheduled event:

Self-Insurance Administrator
County of Warren, New York
1340 State Route 9
Lake George, NY 12845
(518) 761-6529
Office Hours: Monday – Friday, 7:00 a.m. – 5:00 p.m.

Employees who wish to request a specific accommodation in order to perform an essential function of their job duties are asked to complete the form located in Appendix A entitled "ADA Request for Accommodation Form". The completed form should be forwarded to the County Human Resources Director, 1340 State Route 9, Lake George, NY 12845. Once the form is received it will be reviewed by the County Human Resources Director and the Self-Insurance Administrator. The employee may be asked to clarify the information on the request form. The employee will be notified by the County Human Resources Director within 10 business days of the status of the accommodation requests. If the employee is not satisfied with the determination they may follow the Grievance Procedure in Section V of this policy.

APPENDIX A

ACCOMMODATION REQUEST FORM

Name:	Date:
Signature:	Department:

1. What specific accommodation are you requesting?

2. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? ☐ Yes ☐ No

3. If yes, please explain.

4. Is your accommodation request time sensitive? ☐ Yes ☐ No

5. If yes, please explain.

6. What, if any, job function are you having difficulty performing?

7. What, if any, employment benefit are you having difficulty accessing?

8. What limitation is interfering with your ability to perform your job or access an employment benefit?

9. If you are requesting a specific accommodation, how will that accommodation assist you?

Please provide/attach any additional information that might be useful in processing your accommodation.

RETURN THIS COMPLETED FORM TO HUMAN RESOURCES

1340 State Route 9, Lake George , NY 12845 – Fax 518-761-6509

APPENDIX A

ACCOMMODATION REQUEST FORM

I, _____, understand that I am giving permission to the Warren County Human Resources and/or Self-Insurance Departments to contact the following individual(s) for purposes of requesting documentation/information regarding my disability including the diagnosis and limitations associated with that diagnosis.

I understand that this permission will remain in effect from the day I sign this document until I revoke permission in writing or am no longer affiliated with Warren County.

Provider Name:	
Address:	
Phone:	Fax:

Provider Name:	
Address:	
Phone:	Fax:

Provider Name:	
Address:	
Phone:	Fax:

I understand that communication with the above names individual(s) will not include personal disclosures that so not pertain to my disability(ies). I understand that all medical information related to my request for accommodation is confidential and will be maintained in a secured location within the Human Resources Department separate and apart from my personnel file. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of functional limitations on my ability to perform the essential functions of my job.

_____ _____

Signature Date

RETURN THIS COMPLETED FORM TO HUMAN RESOURCES

1340 State Route 9, Lake George , NY 12845 – Fax 518-761-6509

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ACCOMMODATION REQUEST FORM

1. Purchase Requested:

2. Cost (attach documentation):

3. Funding Source/GL Code:

4. Human Resources Review/Approval: _____Date:_____

5. Self-Insurance Review/Approval: _____Date:_____

6. County Administrator Review/Approval: _____Date:_____

7. Personnel Chair Review/Approval: _____Date:_____

Please note - All medical information and supporting documentation related to this request for accommodation is confidential and will be maintained in a secured location within the Human Resources Department.

RETURN THIS COMPLETED FORM TO HUMAN RESOURCES

1340 State Route 9, Lake George , NY 12845 – Fax 518-761-6509