STATE OF MARYLAND

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Response to a Request for Reasonable Accommodation (RRRA)

Requesting Individual's Name:	Program, Service, or Activity Requiring an Accommodation:
Identifying Number (SID, DOC, or DPP #):	Location of Program, Service, or Activity:

Response:

☐ More Information Needed ☐ Request Approved

☐ Request Approved with Modification ☐ Request Denied

Facility or Regional ADA Coordinator Signature: _____ Date: _____

Explanation of delay in response, if any:

☐ The Request for Accommodation form - IRAR (DPSCS.200.0007Ar) was incomplete. Please provide the following information:

_____

Note: A Regional or Facility ADA Coordinator shall contact the inmate, supervisee, or Departmental visitor within 3 business days of receipt of the IRAR Form if an individual's request is delayed due to incomplete or unverifiable information provided on the form or the need for supporting medical documentation. If the Request for Accommodation Form is incomplete, the form must be returned to the individual requesting the accommodation. The individual must sign the acknowledgement below that the individual received this communication and the individual's incomplete original form.

Acknowledgement of receipt of this communication and the original request for accommodation form: _____ Requestor's Signature _____ Date

☐ Exigent Circumstance. A formal response shall be provided to you by: _____ Date

☐ Other Reason (describe):

The reasonable accommodation to be provided (if applicable):

The explanation of the modified reasonable accommodation or denial (if applicable):

If a denial complete the information below:

☐ I, _____, Department ADA Coordinator authorize a denial of this request for reasonable accommodation.

Signature: _____ Date: _____

Summary of Response and Authorized Determination:

Name of approving authority for this response and decision:_____
Managing Official, Regional Administrator, Director, or Commissioner

Signature: _____ Date: _____

This Section to be Completed by the Requestor

Authorized individuals may assist the requestor in completing this form. See Department Directive DPSCS.200.0007

Do you agree with the determination shown above?

☐ Yes, I agree with this determination.

☐ No, I disagree with this determination and have been informed of my right to file a complaint with the Department ADA Coordinator.

Name of Requestor	*SID #:*	*Signature*	*Date*

Distribution: Requesting Individual, Requesting individual's file, Case Manager or Supervising Agent, Facility or Regional ADA Coordinator, Approving Authority, and the Department ADA Coordinator