

## 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 Name: \_\_\_\_\_ Date: \_\_\_\_\_

Facility or Regional ADA Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Explanation of delay in response, if any:**

The Request for Accommodation form - IRAR (DPSCS 200-07aR) was incomplete. Please provide the following information:

\_\_\_\_\_

*Note: A Regional or Facility ADA Coordinator shall contact the incarcerated individual, 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 acknowledgment 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 Circumstances. 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 Dept. 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.

<i>Name of Requestor</i>	<i>SID #:</i>	<i>Signature</i>	<i>Date</i>

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