
 HAWAII HEALTH SYSTEMS CORPORATION <i>Quality Healthcare for All</i> PROCEDURE	Department: Human Resources	Procedure No. HR 0002B
		Supersedes Procedure No.
Subject: Reasonable Accommodations	Approved By:  By: Linda Rosen, M.D., M.P.H. Its: President & CEO	Approved Date: January 27, 2022
		Last Reviewed: October 22, 2021

I. PURPOSE:

To establish procedures for the administration of Policy No. HR 002A, "Reasonable Accommodations."

II. PROCEDURES:

A. Reasonable Accommodation Due to a Disability

1. Individuals with a Disability and female employees disabled due to pregnancy, childbirth, or related medical conditions who believe that a Reasonable Accommodation is necessary in order to perform the Essential Functions of their job or the job that they are applying for should contact the applicable Human Resources ("HR") Department to obtain the necessary information and documents to request Reasonable Accommodation.
2. The Reasonable Accommodation due to a Disability process is triggered if:
 - The employee or applicant requests Reasonable Accommodation and is otherwise qualified to acceptably perform Essential Functions of the job with or without a Reasonable Accommodation, or
 - The employer recognizes the need for a Reasonable Accommodation.

Failure to engage in the interactive process set forth below can lead to liability. The duty to engage in this process is continuing and does not end once HHSC provides one type of Reasonable Accommodation.

3. Upon receipt of a Reasonable Accommodation of Disability Request & Approval Form ("Request for Reasonable Accommodation") (see attached Form 1), a representative of the Corporate or Regional HR office and the position supervisor shall engage in an interactive process with the employee or applicant to discuss the request, which will include identifying the precise limitations resulting from the Disability and the potential accommodations that HHSC might make to allow the employee or applicant to perform the Essential Functions of the job.
4. Upon receipt of the employee's or applicant's signed Authorization for Release of Medical Information for Americans with Disabilities Act ("ADA") Reasonable Accommodations (see attached Form 4), HHSC shall obtain medical information from the employee's treating health care provider that sets forth the specific abilities and limitations of the employee or applicant to help determine whether a Reasonable

Accommodation is feasible given the Essential Functions (as defined by the job description) of the position.

5. HHSC may also choose to have the employee or applicant examined by a physician selected by HHSC to document and substantiate the abilities and limitations of the employee or applicant to perform the Essential Functions of the position.
6. HHSC shall determine whether the requested accommodation creates an Undue Hardship on HHSC.
7. HHSC shall inform the employee or applicant of its decision on the Request for Reasonable Accommodation. If the Request for Reasonable Accommodation is denied and the employee or applicant disagrees with the determination, within ten (10) days of date of the denial, they may submit a Request for Reconsideration of Accommodation Request Due to New Information ("Second Accommodation Request") (see attached Form 2) to the applicable Corporate or Regional HR office.
8. If the Second Accommodation Request is denied, the employee or applicant shall be advised of their right to submit a Third Request for Reconsideration of second accommodation request Determination ("Third Redetermination Request") (see attached Form 3) to HHSC Corporate HR Office within twenty (20) days of the date of the determination of the Second Accommodation Request. The decision of HHSC Corporate is final.
9. The law does not require HHSC to provide the "best" Reasonable Accommodation. HHSC's obligation is to provide an accommodation that allows the individual to perform the Essential Functions of the job effectively, not the accommodation of the individual's choice. Nonetheless, HR will consider the individual's preferred accommodation.

B. Reasonable Accommodations for Religious Beliefs

1. An applicant or employee who believes he or she needs a Reasonable Accommodation due to a sincerely held religious belief should discuss the need for a possible accommodation with his or her supervisor or HHSC Corporate or Regional HR office.
2. Upon receipt of the written request, the position supervisor and a representative of Corporate or Regional HR office shall engage in an interactive process with the employee or applicant to discuss the request and the potential accommodations that HHSC might make to allow the employee or applicant to perform the Essential Functions of the job. The employee may be required to provide documentation to HHSC to verify his or her religious beliefs.
3. HHSC shall determine whether the Requested Accommodation creates an Undue Hardship on HHSC.
4. Absent Undue Hardship, HHSC will provide a Reasonable Accommodation for a sincerely held religious belief, which may include, but is not limited to, flexible scheduling, leave for religious observances, and modified dress or grooming practices.

C. Reasonable Accommodations for Domestic or Sexual Violence Victims

1. An employee who is a victim of Domestic or Sexual Violence and who believes he or she needs a Reasonable Accommodation should contact the HHSC Corporate or Regional HR office.

2. Upon receipt of the written request, the position supervisor and a representative of the Corporate or Regional HR office shall engage in an interactive process with the employee to discuss the request and the potential accommodations that HHSC might make to allow the employee or applicant to perform the Essential Functions of the job. The employee may be required to provide documentation to HHSC to verify that the employee is a victim of Domestic or Sexual Violence.
3. HR shall determine whether the requested accommodation creates an Undue Hardship on HHSC.
4. Absent Undue Hardship, HHSC will provide the employee Reasonable Accommodation which may include, but is not limited to, changing the employee's telephone number or email address, increasing security, screening telephone calls, or allowing flexible hours.

D. Additional Information

An employee or applicant who has questions or concerns regarding the policy or this procedure or both, should contact the applicable Corporate or Regional HR office.

III. ATTACHMENT(S):

- Form 1: Reasonable Accommodation of Disability Request & Approval Form
- Form 2: Request for Reconsideration of Accommodation Request Due to New Information
- Form 3: Final Request for Reconsideration of Determination
- Form 4: Authorization for Release of Medical Information for Americans with Disabilities Act ("ADA") Reasonable Accommodations

HAWAII HEALTH SYSTEMS CORPORATION
REASONABLE ACCOMMODATION OF
DISABILITY REQUEST & APPROVAL FORM

Requestor's Name: _____
Date of Submission of Request: _____ Unit: _____
Doc. No. _____
Requestor is an: ☐ Applicant ☐ Employee
Position Involved: _____
Location: _____
Work or Home Phone No.: _____

- 1) *Identify the Reasonable Accommodation that is being requested:

- 2) Identify the nature of the Disability and the reason the Reasonable Accommodation is being requested:

- 3) Identify and attach to this Form I, any information being submitted to support the request for Reasonable Accommodation:

*Attach any relevant additional documents or use an additional sheet to support this request.

Requestor's Signature Date

Determination

The request for Reasonable Accommodation is:

☐ The agreed upon Reasonable Accommodation is:

☐ No agreement was reached or a Reasonable Accommodation was deemed not warranted because:

If you disagree with this determination, you may submit to me a Request For Reconsideration Of Accommodation Request Due To New Information within ten (10) days of the date of receipt of this determination to further substantiate your request.

Regional Chief Human Resources Officer/Designee	Date
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HAWAII HEALTH SYSTEMS CORPORATION
REQUEST FOR RECONSIDERATION OF ACCOMMODATION REQUEST
DUE TO NEW INFORMATION

Requestor's Name: _____
Date of Request for Reconsideration: _____ Unit: _____
Doc. No. Original Request: _____ Doc. No. Current Request: _____

- 1) Is the same or a different Reasonable Accommodation being requested?
- 2) Has the nature of the disability or the reason for a Reasonable Accommodation changed?
- 3) Is there additional information to support the request for reconsideration? If so, please describe or attach the additional information.

Requestor's Signature Date

Determination

The request for Reasonable Accommodation is approved: The agreed upon Reasonable Accommodation is:

[] No agreement was reached or a Reasonable Accommodation was deemed not warranted because:

If you disagree with this determination, you may submit a Final Request for Reconsideration of Determination within twenty (20) days of the date of this determination to the HHSC Corporate HR Office, 3675 Kilauea Avenue, Honolulu, HI 96816 explaining the reasons for the request. The decision of the HHSC Corporate Office is final.

Regional Chief Human Resources Officer/Designee

Date

Regional Chief Executive Officer

Date

HAWAII HEALTH SYSTEMS CORPORATION

FINAL REQUEST FOR RECONSIDERATION OF DETERMINATION

Requestor's Name: _____
 Date of Request for Reconsideration: _____ Unit: _____
 Doc. No. Original Request: _____ Doc. No. Current Request: _____

Reason(s) requesting redetermination:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins or other markings on the paper.

Requestor's Signature

Date _____

HAWAII HEALTH SYSTEMS CORPORATION**Authorization for Release of Medical Information for
Americans with Disabilities Act ("ADA") Reasonable Accommodations**

Date: _____

Health Care Provider Name: _____

Health Care Provider Address: _____

Health Care Provider Fax Number: _____

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

This form does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

I, _____ [Name of Patient], authorize _____
[Name of Healthcare Provider] to disclose to Hawaii Health Systems Corporation, or any other person authorized by Hawaii Health Systems Corporation, medical information that is specifically related and necessary to determine whether I have a disability and whether accommodations can be made. I authorize Hawaii Health Systems Corporation, or others as authorized by Hawaii Health Systems Corporation, to speak to my treating health care provider directly in regards to any questions with respect to my condition as it relates to the performance of the essential functions of my job and any accommodations that may be necessary, to the extent that it will assist Hawaii Health Systems Corporation to make a decision related to my request for accommodation(s) in a timely manner. I also authorize my treating health care provider to provide information as to whether my condition presents a direct threat to the health and safety of me or others. The persons allowed by this Authorization are only authorized to request information from my treating health care provider that is job-related and does not include genetic information.

Additionally, I authorize _____ [Name of Healthcare Provider] to include in the disclosure of my medical records, records pertaining to: (Please **initial** next to the information that you authorize to be released.)

_____ HIV/ ARC/ AIDS

_____ Mental Health/Psychiatric Services

_____ Treatment for alcohol and/or drug abuse

I understand that the requested information is for the above-mentioned purposes only. I understand that I may refuse to sign this Authorization. However, I understand that if I refuse to sign this Authorization, I am responsible to ensure Hawaii Health Systems Corporation receives the requested medical information. I also understand that this information shall remain confidential, available only under limited conditions specified under law.

This Authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Patient Signature: _____

Date: _____