American with Disabilities Act (ADA) Communication Tool: COVID-19

The purpose of this document is to inform employees about the HCPS process for requesting reasonable accommodations in employment under the ADA related to COVID-19.

American with Disabilities Act
42 United States Code (U.S.C.) Section 12101 to 12103 and 12111 to 12117

The Americans with Disabilities Act (ADA) prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. The ADA covers employers with 15 or more employees, including state, local government, and Harford County Public Schools (HCPS).

A qualified employee with a disability is an individual who, with or without reasonable accommodation, can perform the essential functions of the job in question. The determination of whether any particular condition is considered a disability is made on a case by case basis.

A reasonable accommodation is defined under the ADA as a modification or adjustment to a job, the work environment, or the way things are usually done during the hiring process. Accommodations are considered “reasonable” if they do not create an undue hardship or a direct threat.

HCPS Procedures

- Reasonable Accommodations and Service Animals under the American with Disabilities Act
- Complaint Procedures for Violations of the American with Disabilities Act; Section 504 of the Rehabilitation Act of 1973 and their Implementing Regulations

COVID-19 CDC List of High-Risk Underlying Medical Conditions

The CDC states that, “people of any age with certain underlying medical conditions are at increased risk for severe illness from COVID-19.” Employees, in consultation with their doctor, who are at increased risk for severe illness from COVID-19 may qualify for a reasonable accommodation under the ADA.

Interactive Process

To ensure a reasonable and timely process during COVID-19, there are two pathways identified for ADA accommodation requests depending on the nature of the requested accommodation.

1) If you are seeking a telework accommodation:
   a. Any employee who wishes to make a request for an ADA accommodation for telework capabilities, should notify human resources, benefits@hcps.org, through a written or verbal request.
   b. If an employee’s stated disability or accommodation is not obvious or clear, an HCPS ADA medical questionnaire for the employee’s physician may be requested for completion.
   c. If physically reporting to a building was not an essential function of the employee’s position prior to the COVID-19 pandemic, then this request will be reviewed with the employee’s supervisor.
   d. If physically reporting to a building was an essential function of the employee’s position prior to the COVID-19 pandemic, an assessment will be made regarding ability to complete telework job functions.
   e. If a telework accommodation is determined to not be a reasonable accommodation, employees will receive notice and will be provided with information regarding FMLA and leave policies as applicable.
Interactive Process cont.

2) If you are seeking any accommodation, except for telework:
   a. Any employee who wishes to make a request for an ADA accommodation relating to his/her employment with HCPS should provide a written (utilize attached form) or verbal request to the Risk Management Office.
   b. If an employee’s stated disability or requested accommodation is not obvious or clear, an HCPS ADA medical questionnaire may be requested from the employee’s physician.
   c. Risk management may consult with the requestor and their supervisor as part of the decision-making process.
   d. This is an interactive process whereby the timeline for resolution will depend on the nature of the accommodation. A written decision from the risk management office will clearly state the status of the request for accommodation, and whether a request may be approved, approved with modifications, or denied.

Confidentiality of Medical Records

Personal medical information provided to Harford County Public Schools risk management office is treated as confidential. This is kept in a medical file separate from the personnel file and is filed in a secured location accessible only to designated staff. Personal medical information may be released to supervisors to inform of them work restrictions/ accommodations, or otherwise as required by law. All other release of medical information requires written permission of the employee, a court order, or order from an agency with the authority to compel compliance.
Employee Request for Accommodation
under the Americans with Disabilities Act

Employee Name: ____________________________________________

School/Dept: ______________________________________________

Job Title: _________________________________________________

Supervisor: ________________________________________________

Describe the nature of your disability for which you are seeking an accommodation:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe the specific accommodation you are seeking as a result of your disability:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature: ___________________________ Date: ________________
An employee for the Harford County Public School System (HCPS) has requested an accommodation for a medical condition, under the Americans with Disabilities Act (ADA). To assist HCPS in evaluating this request for accommodation, please answer the following questions with specific detail. The information you provide will be confidential and used only to evaluate the employee’s request for accommodation.

1) Have you examined the employee for a medical condition? □ Yes □ No

Date of most recent examination: ____________________________

2) Does the employee have a physical or mental impairment? □ Yes □ No

If you answered “yes” to question 2:

i) Please identify the specific physical or mental impairment (diagnosis):

_________________________________________________________________________

ii) Is the impairment □ Long-term lasting through ___________ (Time period or date), or □ Permanent

iii) Does the above-identified impairment substantially limit a major life activity of the employee? □ Yes □ No

(1) If yes, please describe what major life activity or activities are affected?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

iv) Does the above-identified impairment impact the ability of the employee to perform essential job functions? □ Yes □ No
(1) If yes, in what specific way(s) and to what extent, does the impairment affect his ability to perform the essential functions of his job? (See attached job description).

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

3) Please state any recommendations regarding possible accommodations to assist the employee in performing the essential functions of his/her job.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

i) How would your suggestion assist the employee in his/her ability to perform the job functions?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

4) Additional Comments:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Physician’s Name (Please print): __________________________________________________
Medical Field: ________________________________________________________________
Phone: ______________________________________________________________________
Physician’s Signature: _______________________________________ Date: _____________

Thank you for taking the time to complete this ADA Medical Questionnaire. If requesting telework, please return the completed form to benefits@hcps.org. For all other accommodations, please return the form to katie.ridgway@hcps.org.