



**Commonwealth of Massachusetts**  
*Executive Office of Health and Human Services*  
**Department of Transitional Assistance**  
600 Washington Street • Boston, MA 02111


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Lieutenant Governor

JUDYANN BIGBY, M.D.  
Secretary

JULIA E. KEHOE  
Commissioner

**Field Operations Memo 2008-20**  
**May 12, 2008**

**To:** Transitional Assistance Office Staff  
**From:**  John Augeri, Assistant Commissioner for Field Operations  
**Re:** ADA Accommodation Requests—Time Requirements

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**Overview**

The Americans with Disabilities Act (ADA) and Department regulations require that DTA make accommodations for persons with disabilities. Field Operations Memo 2007-8 describes DTA's responsibilities regarding requests for these accommodations. Since responses to these accommodation requests must be timely, this memo will identify timelines for responses.

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**Thirty-Day  
Decision  
Timeline**

When an AU Manager receives a reasonable accommodation request from an applicant or client, the TAO Accommodation Team must be informed immediately. The TAO Accommodation Team must make its decision as soon as possible, but no later than 30 days from the applicant's or client's request. If the impairment is not evident, the applicant or client will need to verify that the disability meets the ADA requirements, as well as the need for an accommodation. In these situations, the applicant or client must provide medical documentation of a physical or mental condition that substantially limits a major life activity—such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and/or working—as compared to the ability of a person without a similar impairment to perform the same activity. In addition, if not obvious, the connection between the requested accommodation and the disability must also be documented. The AU Manager should explain to the applicant or client what is needed and offer to assist in obtaining the documentation.

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**Late Verifications**

If the client does not provide necessary documentation by day 30, the TAO Accommodation Team must deny the request due to lack of verification. If verifications are provided after day 30, there is no need for the client to fill out a new request form. Simply annotate the original request form with the date the verifications were received and treat the accommodation request as renewed.

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**Decision Over Thirty Days**

If a decision is not made within 30 days, and the necessary verifications have been received, the applicant or client may choose to file his or her request directly with the Central Office Accommodation Appeal Committee for initial consideration. The AU Manager must inform the applicant or client of this option, and if the applicant or client elects to file directly with the Central Office Accommodation Appeal Committee, the AU Manager must ensure that a copy of the completed ADA-1 (Attachment A) is faxed to the Assistant Commissioner for Field Operations at (617) 348-5659 to begin the consideration process. The Committee must make its decision as soon as possible, but no later than 10 days from the date of the applicant's or client's request. The Central Office Accommodation Appeal Committee may require the AU Manager to contact the applicant or client regarding needed verifications and/or assistance.

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**Timeline for Reconsideration Process**

If an accommodation request is denied by the TAO Accommodation Team or the approved accommodation is different from the one requested, the applicant or client has a right to have the decision reconsidered by the Central Office Accommodation Appeal Committee. This committee has 10 days to make a decision on reconsideration requests. If a decision is not made within this time frame, the applicant or client can request a fair hearing with the Division of Hearings.

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**Approval  
Documentation**

If an accommodation is granted:

- a copy of the approval notice (ADA-2) (Attachment B) should be filed in the case record;
- a designated permanent member of the TAO Accommodation Team must also keep a copy of the notice;
- the BEACON Narratives tab must be annotated, explaining the accommodation and whether the accommodation need is ongoing. When entering the Narrative, always begin the Narrative with “ADA” to ensure that the accommodation can be readily identified;
- create a “yellow post-it note” on BEACON noting the accommodation.

**Remember:** The Department has an obligation to assist all applicants and clients. AU Managers should always assist individuals who need help filling out applications, obtaining verifications, understanding notices and/or policies, etc., regardless of whether or not they have a disability.

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**The  
Accommodation  
Process**

For procedures on the accommodation process please see Field Operations Memo 2007-8.

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**Questions**

If you have any questions, please have your Hotline designee call the Policy Hotline at 617-348-8478.

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Massachusetts Department of Transitional Assistance  
**REQUEST FOR AN ADA ACCOMMODATION**

- Initial Request
- Modification of Initial Request

\_\_\_\_\_  
TAO

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant/Recipient Name

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Street Address/City/ZIP

**Reason for ADA Accommodation Request**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Requested ADA Accommodation**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

_____ <b>Applicant/Recipient Signature</b>	_____ <b>Date</b>	_____ <b>AU Manager Signature</b>	_____ <b>Date</b>
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The Department has thirty (30) days to make a decision on your request. If a decision is not made within thirty days, you may file your accommodation request directly with the Central Office Accommodation Appeal Committee. Please see the back of this form. The Appeal Committee will have ten (10) days to make its decision.

**If you have trouble reading or understanding this notice, please feel free to call Recipient Services at 1-800-445-6604. We can help explain it to you.**

**Decision:**     **Approved**             **Denied**

Approved Accommodation (if any): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for denial, if applicable: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT: If you disagree with the decision reached by the TAO Accommodation Team you have the right to reconsideration by the Central Office Accommodation Appeal Committee. You must make your request for reconsideration within 45 days of this decision. Please see the back of this form.**

\_\_\_\_\_  
**Department Representative Signature**

\_\_\_\_\_  
**Date**

**REQUEST FOR AN ADA ACCOMMODATION RECONSIDERATION**

If you have trouble reading or understanding this notice, please feel free to call Recipient Services at 1-800-445-6604. We can help explain it to you.

I disagree with the decision on the reverse side of this notice and request the decision be reconsidered.

\_\_\_\_\_  
Applicant/Recipient Signature

\_\_\_\_\_  
Date

**Return to:**

**Department of Transitional Assistance  
Assistant Commissioner for Field Operations  
600 Washington Street, 4<sup>th</sup> Floor  
Boston, MA 02111**

**IMPORTANT: The Central Office Accommodation Appeal Committee will have ten days to make its decision. If the Central Office Accommodation Appeal Committee upholds the TAO Accommodation Team decision, you have the right to a Fair Hearing.**



Massachusetts Department of Transitional Assistance  
**CENTRAL OFFICE ACCOMMODATION APPEAL  
COMMITTEE REVIEW FORM**

Attachment B

If you have trouble reading or understanding this notice, please feel free to call Recipient Services at 1-800-445-6604. We can help explain it to you.

\_\_\_\_\_  
TAO

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant/Recipient Name

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Street Address/City/ZIP

**This is to inform you that the Central Office Accommodation Appeal Committee has reviewed your request for a Reasonable Accommodation and have:**

Approved an ADA Accommodation as described below.

Denied your request for an ADA Accommodation.

If approved, description of ADA Accommodation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If denied, reason for denial \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you disagree with the decision reached by the Central Office Accommodation Appeal Committee you have the right to a Fair Hearing. The reverse side of this notice contains important information about your hearing rights. You must request this Fair Hearing within 90 days. To request a hearing, complete the reverse side of one copy of this notice. You also have the right to file a claim with the Massachusetts Commission against Discrimination and/or the Office for Civil Rights of the U.S. Department of Health and Human Services. You may also contact your local legal services office for more information about your rights.**

\_\_\_\_\_  
Accommodation Team Representative Signature

\_\_\_\_\_  
Date



**Notice of Request for a Fair Hearing**  
**Massachusetts Department of Transitional Assistance**  
 Division of Hearings  
 P.O. Box 120167, Boston, Massachusetts 02112-0167

**Attachment B**

**If you have trouble reading or understanding this notice, please feel free to call Recipient Services at 1-800-445-6604. We can help explain it to you.**

**YOUR RIGHT TO APPEAL:** If you disagree with any action or inaction taken by the Department of Transitional Assistance (DTA), you have the right to appeal and receive a fair hearing before an independent referee. DTA must receive your request for a fair hearing no later than 90 days from the date on this notice. Exceptions to the 90-day time limit are: (1) you have 21 days to request a hearing on Emergency Assistance (EA) shelter benefits, (2) you have 30 days from the date of mailing of the notice by the Department of Revenue to request a hearing regarding the intercept of your state tax refund, (3) you may appeal the amount of your Food Stamp (FS) benefits at any time during your FS certification period, if you think you are not receiving the correct amount, (4) you have up to 120 days if DTA fails to act on your request for services, and (5) you have up to 120 days to appeal alleged coercive action or otherwise improper conduct or up to one year under certain specified circumstances.

**HOW TO APPEAL:** If you wish to request a fair hearing, send this page with the bottom section completed to: **DTA, Division of Hearings (DOH), P.O. Box 120167, Boston, Massachusetts 02112-0167 or fax to (617) 348-5311.** Please keep the copy for your own records.

**IF YOU ARE CURRENTLY RECEIVING BENEFITS, READ THIS SECTION:** Your benefits will be continued until a decision is made on your appeal if DOH receives your appeal request within 10 days from the date on this notice. If you are appealing a FS issue, and your FS certification period ends before your appeal is decided, you will continue to receive the same FS benefits only until the end of your certification period. If you receive benefits during your appeal, but lose your appeal, DTA can recover the benefits to which you were not entitled. If you receive TAFDC time-limited benefits during an appeal, which you then lose, the months for which you have received benefits will count toward your time-limited benefits. If you do not wish to continue to receive benefits during your appeal, check Box A below. If you do not receive benefits during your appeal, and you win your appeal, DTA will promptly correct any underpayment.

**WHEN THE HEARING WILL BE HELD:** You will be given at least 10 days notice prior to the fair hearing of the date, time and place of the hearing to permit you time to prepare your case. If you wish to have a fair hearing scheduled sooner, check Box B below. Fair hearings on EA shelter benefits are expedited; you will be given at least two days notice prior to the fair hearing of its date, time and place. If you have good cause for not being able to attend the fair hearing, please contact DOH at (617) 348-5321 or 1-800-882-2017 (TTY (617) 348-5337 or 1-800-532-6238 for the Deaf or hard-of-hearing), before the hearing date, so that your hearing can be rescheduled. Failure to appear at the fair hearing without good cause may result in the dismissal of your appeal, except for the first scheduled hearing involving any aspect of the FS Program where good cause for rescheduling need not be demonstrated.

**YOUR RIGHT TO BE ASSISTED AT THE HEARING:** If you cannot speak English or understand it well or if you are Deaf or hard-of-hearing and wish to have DOH provide an interpreter, please write that on this appeal request or call DOH at (617) 348-5321 or 1-800-882-2017, (TTY (617) 348-5337 or 1-800-532-6238) at least a week before the hearing. At the hearing, you may be accompanied by an interpreter, attorney, or other representative at your expense. You may wish to contact a local legal services office or community agency for assistance. Information about local legal services offices and other services provided by community agencies in your area can be obtained by contacting your local office. These agencies may provide advice or representation at no cost to you.

You or your representative may subpoena witnesses, present evidence and cross-examine witnesses. The referee must make a decision on all evidence presented at the fair hearing. You or your representative will be permitted to see your case file before the hearing. If you want to review your case file, schedule an appointment with your worker before the hearing.

**NONDISCRIMINATION NOTICE FOR CLIENTS:** Under federal and state law the Massachusetts DTA does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age or disability. If you have any questions or concerns, we encourage you to contact the Director of Equal Opportunity, DTA, 600 Washington Street, Boston MA 02111, Tel. (617) 348-8490 (TTY (617) 348-5532 for the Deaf or hard-of-hearing).

I, \_\_\_\_\_, hereby request a fair hearing before a referee of DOH.

- A. I do not wish to continue receiving the disputed amount of benefits during the appeal process.
- B. I request an expedited hearing.

The reason I wish to request a fair hearing is \_\_\_\_\_  
 \_\_\_\_\_

Your Name (Print) \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

City/ZIP \_\_\_\_\_ Date \_\_\_\_\_

Your Signature \_\_\_\_\_

My authorized representative is: Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ City/ZIP \_\_\_\_\_

Telephone ( ) \_\_\_\_\_