

JOB CORPS REASONABLE ACCOMMODATION FUNDING REQUEST FORM

Centers are responsible for any costs associated with providing reasonable accommodation to an applicant or student with a disability. If a center cannot fund an accommodation or locate a funding source in the community, a request can be made through the appropriate Regional Office for National Office funding assistance for high cost accommodations (those greater than \$5,000).

All requests for funding assistance should be made as part of the accommodation process; funding requests for accommodations already provided will not be considered. National Office funding for medications and personal use items is not available. This form can only be used to request funding assistance for an individual applicant or student; no requests that contain multiple students on the same form will be considered.

Please complete the appropriate section of the following form. All requests should be expedited so as not to unreasonably delay entry or provision of accommodation to the applicant/student. If you need assistance with the form, or would like to see a sample completed form, contact your Regional Disability Coordinator.

A. CENTER DISABILITY COORDINATOR		
<i>This section of the form should be completed and sent to your Regional Disability Coordinator within 7 days of the applicant's or student's reasonable accommodation team meeting.</i>		
Center Disability Coordinator:	Position:	
Phone:	E-mail:	
Applicant/Student Name:	Date(s) Met with Applicant/Student to Discuss Accommodation(s):	
Describe the nature of the applicant's/student's disability/functional limitation.		
In the space below list each accommodation that funding is being requested for and provide the estimated cost for each accommodation (budget may be attached). Please indicate if the accommodation has a one-time cost (e.g., software, equipment) or an ongoing cost (e.g., sign language interpreter) for which additional funding may be needed.		
Accommodation:	Estimated Cost:	One-time Cost/Ongoing Annual Cost:
	Total Estimated Cost:	

List other possible funding sources consulted along with their contact information. If any funding is being provided by these sources, please list amount.	
How will this/these accommodations remove or minimize the barriers presented by the applicant's/student's functional limitation(s)?	
Were any alternate accommodations considered? If yes, list and describe why not chosen.	
If you are requesting funding for a sign language interpreter, have you reviewed the deaf/hard of hearing guidance available on the Job Corps Disability website, including the guidance on interpreting services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List any other accommodations that are being or will be provided.	
Disability Coordinator Signature:	Center Director Signature:
Date Forwarded to Regional Disability Coordinator:	
B. REGIONAL DISABILITY COORDINATOR	
<i>Please review the center's request. If the center section of the form is not complete or inadequate information has been provided, please contact the Center Disability Coordinator to resolve these concerns. If the center section of the form is complete and adequate information has been provided, please complete this section of the form and send it to the regional office program/project manager within 7 days of receipt from the center.</i>	
Regional Disability Coordinator:	E-mail:
Phone:	Date Request Received:
Date Request Reviewed:	Date Forwarded to Regional Office:
Regional Disability Coordinator Signature:	
C. REGIONAL OFFICE	
<i>Please review the center's request and send to:</i>	
<p style="text-align: center;"><i>National Health Staff Department of Labor Office of Job Corps 200 Constitution Ave., NW, RM. N-4507 Washington, DC 20210</i></p>	

<i>This request should be reviewed and sent to the National Office within 5 days of receipt from the regional disability coordinator.</i>	
Program/Project Manager:	Phone:
E-mail:	Date Request Received:
Date Request Reviewed:	Program/Project Manager Signature:
Regional Director Signature:	Date Forwarded to National Office:
D. NATIONAL OFFICE-NATIONAL HEALTH STAFF	
<i>This request should be reviewed and forwarded to the National Director within 5 days of receipt of this request from the Regional Office.</i>	
National Office Health Staff Person:	Position:
Phone:	E-mail:
Date Request Received:	Date Request Reviewed:
Date Request Forwarded to National Director:	
E. NATIONAL OFFICE INFORMATION-NATIONAL DIRECTOR	
<i>Indicate approval or disapproval of funding for this request below and sign. If the request is approved, forward to Budget Office. If the request is disapproved, forward to the National Office staff person you designate to make the notification.</i>	
Disposition: <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	
Amount Approved (if different from original request, please explain):	Disposition Date:
National Director Signature:	
F. NATIONAL OFFICE-FINAL DISPOSITION	
<i>If funding is approved a staff person from the Health and Wellness Unit will notify the Center Director and Regional Office Program/Project Manager. If the request is disapproved, the designated National Office staff person will notify the Center Director and Regional Office Program/Project Manager. The Regional Disability Coordinator should also receive a copy of the final response. All requests should be maintained in a secure file.</i>	
National Office Staff Making Notification:	Position:
Phone:	E-mail:

Date Final Disposition Received:	Date Center/Region Notified:
National Office Staff Signature:	