

Manatee County Natural Resources Department

Americans with Disabilities Act Compliance Procedures

Overview

Manatee County programs and facilities will be operated in a non-discriminatory manner, and every reasonable effort will be made to provide persons with disabilities access to Natural Resources programs and facilities as required by law. No person may be excluded from participation in, admission or access to, denied the benefit of, any program or facility simply because such person has a qualifying disability. Accommodations, which may include modifications or exceptions to certain rules or procedures, will be provided so long as they do not result in a fundamental alteration in the nature of the program or activity, create a significant risk of danger to employees or the person or other persons using the facilities or participating in the programs in question, impose an undue hardship by causing significant difficulty or expense when considering the Department's size, financial resources and nature and structure of its operation, and does not constitute a violation of state or federal law or otherwise jeopardize the Department's ability to perform the major function of its mission and operations. The following sections outline the processes the Department will follow to ensure persons with disabilities are provided reasonable accommodation and access to its facilities and programs.

Program/Facility Accommodation Requests

In order to fully understand and adequately respond to requests for accommodation, the Department requests that persons seeking accommodations to be able to participate in its programs or access its facilities complete and submit its "ADA Accommodation Request Form." This form may be accessed at the main offices of the Natural Resources Department, located at 415 10th Street West, Bradenton, Florida 34205, or by visiting the Department's web page, at: www.mymanatee.org. Persons seeking assistance in completing or filing the form may contact the Department at 941.745.3727. To help ensure timely response, accommodation requests should be submitted when an individual first makes application for a permit, where one is required, for program or facility access. Accommodation requests filed after that date will nevertheless be accepted but applicants concerned about possible delays related to verification or establishment of accommodation measures should make every effort to file a timely request.

Requirements and Conditions

1. In order to verify ADA accommodation eligibility, the Department will generally require, as an attachment to an accommodation request, a written statement by a licensed physician or other qualified medical professional confirming the person seeking accommodation does have an ADA qualifying disability, and, where needed, confirming that a given proposed accommodation will otherwise allow the person to participate in the program or access the facility without creating a danger to the person, employees, or others the person may come into contact with.

2. The Department also asks that an accommodation request include a description of the type/form of accommodation being requested, with as much detail as possible, so that it may quickly review the proposed accommodation and either approve of it, deny it for a legally permissible reason, or work with the applicant to craft an alternative which may help reduce costs, risks to others, or would otherwise be reasonable and still allow access and participation.
3. Once a permit and accommodation are authorized, the permit holder must follow all rules, policies, and procedures associated with the program, permit, and approved accommodation.
4. Approved permits, along with any documents demonstrating Department-approved accommodations, must be kept in the physical possession of the permit holder at all times when engaged in the permitted activity or accessing the permitted facility, and must, on request, present same to any Manatee County personnel, law enforcement officer, or state or federal official with jurisdiction covering the program or facility at issue.

Accommodation Request Review

Requests for accommodation which have been completed and contain all needed information will be reviewed by the Department Director or his/her designee. The Director or designee shall, where appropriate, consult medical resources and/or the County Attorney's Office to assist in providing a sufficient response. The Department will make every effort to provide a response within 45 days of receipt. Applicants will be notified of the Department's response in writing, and, where the Department determines that an accommodation will not be provided, it will include in its response an explanation as to the reasons why the accommodation was not able to be granted.

A person other than the individual with a disability may request a reasonable accommodation on behalf of the individual, though all required documentation will still be required, and the person with a disability will still be bound to comply with all of the terms and conditions of any resulting permit, and conditions of accommodation. Where a requestor is unsatisfied with the Department's disposition of an accommodation request, he/she may request review by the County Administrator, who will consult with the County Attorney's Office as needed and inform the requestor of the County's final position on the request.

Medical Records and Privacy

Manatee County Natural Resources Department will maintain all medical documentation submitted pursuant to these accommodation procedures as confidential and exempt from disclosure to the full extent provided for by federal and state law. No member of County staff will directly contact your physician. Instead, if staff have any questions or need follow up information, you, the applicant, will be asked to obtain same from your physician and forward it to staff.

(approved by CAO via RLS 08-210)

Manatee County Natural Resources Department

ADA Accommodation Request Form

Please Print:

Name: _____

Date: _____

Mailing Address: _____

Daytime Phone Number: _____

Statement of Disability

I hereby certify that I have the following physical or mental impairments which qualify under the Americans with Disabilities Act as disabilities eligible for a reasonable accommodation (*please attach physician certification as relevant*):

Description of Accommodation Request

I hereby request an accommodation of my disability to access the following facility or participate in the following program:

The accommodation I request is as follows (*please describe in detail the nature of your request and any steps you feel the agency may take to make accommodation. Use additional paper if necessary*):

Print Name

Signature

Date

Staff Use Only

This request was received on _____, by _____ (insert staff initials)

This request was ___approved___ approved as modified ___declined by _____
on _____ (date).

(note, if request denied, written reason(s) must be attached and maintained in the file)

Manatee County Natural Resources Department

Disability Eligibility Certification

(Print Applicant's Name)

(Address) (City) (State) (Zip)

Home Telephone (____) _____ Date of Birth: Month ____ Day ____ Year ____

Sex ____ Race ____ Height ____ Weight ____ Eye Color ____ Hair Color ____

I hereby authorize my physician or other relevant medical professional to disclose the information in the attached Physician's Certification as part of my request for an accommodation of my disability to the Manatee County Natural Resources Department

Applicant Signature Date

Manatee County Natural Resources Department

Physician's Certification Form

This is to certify that _____ has the following physical or mental impairment(s) which make my patient eligible to request a reasonable accommodation:

I further certify that I have been informed of the public program my patient desires to participate in, and/or the public facility my patient desires to gain access to, and in my professional opinion the accommodation being requested will allow my patient to successfully do so, and will not thereby create a significant risk of danger to my patient or to other persons with whom my patient comes into contact.

Print Physician's Name Physician's Signature

Date signed: _____