Department of Homeless Services
Department of Social Services

HEAT SENSITIVITY FACT SHEET

As temperatures rise, we are letting you know that certain medicine may make you more sensitive to heat. These include:

TRADE NAME	GENERIC NAME
Abilify	aripiprazole
Clozaril/Fazaclo	clozapine
Fanapt	iloperidone
Geodon	ziprasidone
Invega/Sustenna	paliperidone
Latuda	lurasidone
Risperdal/Consta	risperidone
Saphris	asenapine
Seroquel	quetiapine
Zyprexa	olanzapine

TRADE NAME	GENERIC NAME
Haldol	haloperidol
Loxitane	loxapine
Mellaril	thioridazine
Navane	thiothixene
Prolixin	fluphenazine
Serentil	mesoridazine
Stelazine	trifluoperazine
Thorazine	chlorpromazine
Trilafon	perphenazine

If you take one of these, or if you have a medical condition that makes it hard for you to tolerate heat, you can ask for a reasonable accommodation. A reasonable accommodation is a type of help that we can provide you. It can include something like air conditioning.

You can request a reasonable accommodation by filling out the attached form.

If you take any of the medications listed above, please include a copy of your prescription or a photo of the medicine bottle with your name on it and/or a letter from your doctor with the request. If you have a medical condition that makes it hard for you to tolerate heat, please include a letter from your doctor.

If you have any questions, please contact your on-site director.

COMPLETE NEXT PAGES TO REQUEST A REASONABLE ACCOMMODATION

Department of Homeless Services
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REASONABLE ACCOMMODATION REQUEST FORM

INSTRUCTIONS: Clients must complete Section I and submit this form along with supporting documentation to the Program/Facility Director, or functional equivalent ("Director"). Any Director receiving a completed form with appropriate medical documentation must complete Section II, return a copy to the client, and immediately transmit by facsimile the request and supporting documents to the appropriate Program Administrator, and the Office of Diversity & Equal Opportunity Affairs.

Section I: (This section must be completed by the client.)

Name: _____

Address/Facility/Program: _____

Social Security #: _____ Telephone: _____

Describe the Accommodation Requested (attach additional sheets and supporting documentation as appropriate).

_____

_____

_____

_____

_____

_____

Section II: (To be completed by the Director or his/her designee.)

Name/Title: _____

Facility/Program: _____

Address: _____

Telephone: _____ Date Received: _____

Signature: _____

After completing this section, the Director must give a copy of this form to the client and immediately fax the request to the appropriate Program Administrator, Program Analyst and the Office of Diversity & Equal Opportunity Affairs, 33 Beaver Street, New York, New York 10004/Tel. 212-361-7914/ Fax. 212.361.7915/ eoa@dhs.nyc.gov.

Section III: (To be completed by the Program Administrator or his/her designee.)

Name/Title: _____

Telephone: _____ Date Received: _____

Signature: _____

Detailed record of the accommodation review process, including but limited to: a description of medical documentation received; Director/Program Administrator comments; notes regarding consultations with DHS Medical Director and, as needed, Client Advocacy; proposed accommodations; final determination.