# **Template request for reasonable accommodation/modification from a person with a bleeding disorder**

## [*insert Date*]

## [Insert name of Substance Use Disorder/Mental Health Treatment Facility]

## [Insert Address of Facility]

## Dear [Insert Name of Facility Administrator]:

## I am a person with a disability as defined under the Americans with Disabilities Act (ADA) and the Rehabilitation Act, and I am requesting treatment at your facility. This disability classification means that I have a physical or mental impairment that substantially limits one or more of my major life activities. My disability requires that I receive [insert IV or injection] treatment [insert schedule e.g., weekly] to prevent bleeding-related harm.

## The ADA prohibits discrimination on the basis of disability in the provision of health care. Discrimination includes refusing “to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person [insert diagnosis with hemophilia A or hemophilia B or other BD] equal opportunity to access medical care, including access to [inpatient/ residential substance use disorder treatment/ inpatient mental health treatment].”

## In order to ensure that I have an equal opportunity to access medically necessary care, I am requesting the following reasonable accommodation/modification(s):

* Access to prescribed bleeding disorder medication: [insert name of prescribed medication]
* Secure, climate-controlled storage for bleeding disorder medication and associated medical supplies
* Time during the day to receive bleeding disorder medication
* Permission to administer (self-infuse or inject) the bleeding disorder medication or a provider to administer the bleeding disorder medication (staff or external)
* Access to a private space in which to administer the bleeding disorder medication (e.g., a medication room or a private office)
* Presence of a staff member to ensure that only the bleeding disorder medication is infused and the supplies are not misused.

## I have attached verification of my disability from [insert name of your healthcare professional/ BD provider], which describes the functional limitations I experience and the accommodation/modification(s) I need.

## Please reply to my request in writing within the next three (3) business days.\* If you have any questions about my request, please do not hesitate to contact me at [insert your phone number and/or email address]. I look forward to your response and appreciate your prompt attention to this matter.

## Sincerely,

## [insert signature]

## \*Providers have an obligation to provide a prompt response to a reasonable accommodation/modification request.