HEAT SENSITIVITY FACT SHEET

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

<table>
<thead>
<tr>
<th>TRADE NAME</th>
<th>GENERIC NAME</th>
<th>TRADE NAME</th>
<th>GENERIC NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
<td>Haldol</td>
<td>haloperidol</td>
</tr>
<tr>
<td>Clozaril/Fazaclo</td>
<td>Clozapine</td>
<td>Loxitane</td>
<td>loxapine</td>
</tr>
<tr>
<td>Fanapt</td>
<td>Iloperidone</td>
<td>Mellaril</td>
<td>thioridazine</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
<td>Navane</td>
<td>thiothixene</td>
</tr>
<tr>
<td>Invega/Sustenna</td>
<td>Paliperidone</td>
<td>Prolixin</td>
<td>fluphenazine</td>
</tr>
<tr>
<td>Latuda</td>
<td>Lurasidone</td>
<td>Serentil</td>
<td>mesoridazine</td>
</tr>
<tr>
<td>Risperdal/Consta</td>
<td>Risperidone</td>
<td>Stelazine</td>
<td>trifluoperazine</td>
</tr>
<tr>
<td>Saphris</td>
<td>Asenapine</td>
<td>Thorazine</td>
<td>chlorpromazine</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
<td>Trilafon</td>
<td>perphenazine</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

(Turn page)
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.

(Turn page)
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.

________________________________________________________________________________
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