COMPUTER/ELECTRONIC ACCOMMODATIONS PROGRAM (CAP) ACCOMMODATION REQUEST

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the CAP Portal and how it will be used.

AUTHORITY: 10 U.S.C. 1582, Assistive Technology, Assistive Technology Devices, and Assistive Technology Services; 29 U.S.C. 794d, Electronic and Information Technology; 42 U.S.C. Chapter 126, Equal Opportunity for Individuals With Disabilities; and DoD Instruction 6025.22, Assistive Technology (AT) for Wounded, Ill, and Injured Service Members.

PRINCIPAL PURPOSES: To collect information from an individual in order to determine whether that individual qualifies for the CAP and what assistive technology is appropriate for that individual.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: Collected information may be disclosed to Federal Government agencies partnered with CAP in order for each agency to meet requirements outlined in its CAP partnership agreement. Information may be provided to CAP Representatives (see links below) in the requesting individual's agency, as well as supervisors or others whose contact information is entered into the CAP Accommodation Request form. Information may be provided to commercial vendors to permit the vendor to identify and provide assistive technology solutions for individuals with disabilities. The applicable system of records notice is DHRA 15 DoD, Computer/Electronic Accommodations Program, and is located at: **http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570768/dhra-15-dod/**

DoD Agency CAP Representatives: **http://www.cap.mil/Customers/DoDEmployees/DoDAgencies.aspx**

Non-DoD Partners A-L: **http://www.cap.mil/Customers/NonDoDEmployees/PartnerAgenciesAL.aspx**

Non-DoD Partners M-Z: **http://www.cap.mil/Customers/NonDoDEmployees/PartnerAgenciesMZ.aspx**

DISCLOSURE: Voluntary. However, failure to provide the requested information may result in you being considered ineligible for any CAP services.

INSTRUCTIONS

Complete this form to request assistive technology and services. Please ensure completion of all contact information. If you have any questions, please call CAP at (703) 614-8416 or (833) 227-3272 (V), or email cap@mail.mil. You may also complete the request form online at www.cap.mil to expedite request processing.

Only individuals who are Department of Defense employees (to include Active Duty Service members), or employees of Federal Government agencies partnered with CAP are eligible for CAP services. If you are a disabled veteran and are not employed by the Federal government, please contact the Department of Veterans Affairs for assistance.

1. PERSON TO BE ACCOMMODATED

a. Name *(Last, First, Middle Initial)*	**b. Have you used cap services before?** ☐ **Yes** ☐ **No**

2. DELIVERY AND CONTACT INFORMATION *(Do not use acronyms or Post Office boxes)*

a. Agency

☐ **DoD** ☐ **Non-DoD**	**Specify Agency:**

b. Delivery address *(Work address)*

Address:

City:	**State:**	**Zip Code:**

c. Contact information

(1) Telephone/TTY *(Include area code)*	**(2) Fax** *(Include area code)*	**(3) Email**	**(4) Secondary Email**

3. DISABILITY INFORMATION

a. What are the functional limitations related to your task(s)? *(X all that apply)*

☐ **Blind (e.g., legally blind)**

☐ **Low Vision (e.g., difficulty seeing characters on a screen or printed page)**

☐ **Cognitive (e.g., difficulty focusing on printed or spoken information, expressing information, remembering things)**

☐ **Communication (e.g., difficulty communicating)**

☐ **Deaf/Hard of Hearing (all degrees of hearing loss)**

Specify condition:

b. Are you currently on active duty with the U.S. Military? ☐ **Yes** ☐ **No**	**c. Were you injured while on active duty with the U.S. Military?** ☐ **Yes** ☐ **No**

4. ITEM REQUESTED

Include brand name/model and attach any additional information you may have. If you are a Workers Compensation claimant or if you participate in telework, please attach a copy of your Department of Labor Claim Acceptance Letter or Telework Agreement.

a. Item(s) requested	b. Brand(s)/model(s)

c. Addition information

d. Workers' compensation claim number *(If applicable)*

e. Do you participate in telework?	f. If yes, will this (these) accommodation(s) be used at your telework location?
☐ Yes ☐ No	☐ Yes ☐ No

5. JUSTIFICATION

a. Please provide a detailed description of your daily job tasks for which the requested items or services will be used to support:

b. Please describe your limitations and how they impact your ability to perform your essential job functions:

c. Please describe any assistive technology you have used and in what type of setting (i.e., personal, school, on the job):

6. TRAINING COURSE REQUIREMENTS

Note: Complete this section only if you are a DoD employee attending a job-related training course of two or more days.

a. Requested service *(X one)* ☐ **Interpreting*** ☐ **CART*** ☐ **Travel Reimbursement for Personal Assistant****

*Interpreting and CART services are provided for DoD employees to attend job related training lasting two days or longer, but not to exceed two weeks. Interpreting and CART services are also provided for the first day of employment for DoD employees hired via the Workforce Recruitment Program.
*It is strongly recommended that this completed form, and proof of course enrollment for training related requests, be submitted for consideration at least 20 business days in advance. Incomplete requests or requests received less than 15 business days in advance will not be considered. Services are dependent upon many factors, including geographic location and the availability of interpreting and CART professionals. Therefore, services are not guaranteed.
**Travel Reimbursement for Personal Assistant are for DoD employees ONLY to attend job related training, two (2) or more days in length and not to exceed two (2) weeks. This request should also be accompanied with a CAP Personal Assistant (PA) Travel Information Form.

b. Course/training session *(Attach a course description and proof of registration to this form)*

(1) Course/Training Title	(2) Course Location	(3) Dates *(From - To (YYYYMMDD))*	(4) Start and End Times Each Day

c. On site point of contact

(1) Name *(Last, First, Middle Initial)*	(2) Title	(3) Telephone *(Include area code)*	(5) Email

7. EMPLOYEE OR SERVICE MEMBER SIGNATURE

a. Name *(Last, First, Middle Initial)*	b. Signature	c. Date signed

8. APPROVING OFFICIAL/SUPERVISOR

a. Name *(Last, First, Middle Initial)*	b. Title	c. Telephone/TTY *(Include area code)*	d. Email

e. Approving official/supervisor signature*	f. Date signed

*Signature serves as verification that the requested equipment fulfills a valid federal government requirement and, if applicable, you will work with appropriate IT personnel to have the equipment function on the agency's network.