PUBLIC INTERST LAW CENTER OF PHILADELPHIA

CONSULTATION SERVICES QUESTIONNAIRE

NOTICE

This form is to help determine eligibility for the Public Interest Law Center of Philadelphia’s disability-based employment discrimination legal services for clients in Pennsylvania. Please complete this form ONLY if you are seeking legal help with an employment issue, and only if you reside in Pennsylvania.

**Please be on notice: By agreeing to a consultation, we are not agreeing to take your**

**case. We do not represent you at this time. We will review the information you provided and if you are eligible we will contact you within 2 weeks. If you are not eligible, we will notify you within 60 days.**

Please note we do not accept intake over the phone. You must complete this form to be considered for eligibility for legal services. You can complete this form online, or you can mail, email or fax a copy with any supporting documents. If you have copies of documents that support your claim, please submit them with your form. You can also mail copies (no originals please—they will not be returned), email, or fax copies to:

Disability Employment Discrimination

1709 Benjamin Franklin Parkway, Second Floor

Philadelphia, PA 19103

Fax: 215-627-3183

Email: disabilityintake@pilcop.org

**All of the information that you provide will be kept confidential.**

Please contact us immediately if your work situation changes.

If you have an advocate or someone who assists you, please indicate whether you wish to have that individual contacted prior to our meeting and provide us written permission to do so by **signing the release form** at [www.pilcop.org/disability-employment-discrimination](http://www.pilcop.org/disability-employment-discrimination)

Please know that the problem you have is very important to us. We can best help you if we have as much information as possible, so please fill out this form COMPLETELY. Any information you provide will be kept confidential. If there is a question that you do not know the answer to, state you do not know. Do your very best to answer all the questions, as it will delay our ability to review your situation. If you have difficulty completing it, talk to a friend or advocate. Feel free to add additional pages of explanation.

If you need accommodations or assistance to complete this form, please contact us or have someone contact us on your behalf. For those with intellectual disabilities who need help completing this form, Vision for Equality has advocates who may be able to help you.

**SECTION I: BASIC INFORMATION**

Please answer each question. If you do not know the answer, please write that you do not know.

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our income eligibility is 150% of the federal poverty line.\* Do you meet this income guideline?

Yes No

\*In 2014 150% of the poverty line is annual income no more than for a single family household, $23,340 for a 2 person family, $29,685 for a family of 3; $35,775 for a family of four, $41,865 for a family of 5; and $47,955 for a family of 6.

Is there someone who assists you who we should contact on your behalf? Please complete the attached release form [online version link], and provide the following information:

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION II:DISABILITY**

Please answer each question. If you do not know the answer, please write that you do not know.

1. Please list the mental or physical conditions that form the basis of your disability

2. Date you were first diagnosed with this condition:

a. Were any of your conditions diagnosed after you began your job?

3. Please list the major life activities and/or the major bodily functions that your condition(s) severely impair(s):

caring for oneself

performing manual tasks

seeing

hearing

eating

sleeping

walking

standing

lifting

bending

speaking

breathing

learning

reading

concentrating

thinking

communicating

working

functions of the immune system

normal cell growth

digestive

bowel

bladder

neurological

brain

respiratory

circulatory

endocrine

reproductive functions.

Other \_\_\_\_\_\_\_\_\_\_\_\_

Have you filed a complaint with any agency (EEOC, PCHR, PHRC, etc.) about this case?

If yes, when?

What agency?

Please attach a copy of all correspondence from the agency with your application.

Do you have an attorney currently working with you on this case?

If yes, who?

Will you need assistance or services in our representation of you?

Yes No

If yes, what services or assistance will you require:

**SECTION III. GENERAL**

If your claim is based on a failure to hire—you applied for a job and believe you were not hired because of your disability—please answer these questions for the job you applied to

Please answer each question. If you do not know the answer, please write that you do not know.

**A. Employer**

1. Name of Employer:

2. Address of employer:

3. Number of Employees (check one)

0-5 5-15 50-50 50-100 100-500 500+

3. Name and title of Supervisor:

4. Does the organization have an HR (Human Relations) department?

5. Does the organization have a union?

**B. Your Job**

1. Job Title:

2. Job Description:

Please provide copies of any job descriptions from the employer, such as job postings, handbooks or webpages describing your job

3. Your qualifications for the job: skills, experience, education (you may attach a resume)

4. Dates held your current position

b. Dates worked at the organization in any other position

5. Have you informed your employer of your disability? Y/N

a. Date informed

b. In writing? Y/N

c. Did you provide copies of your medical information? Y/N

d. Name of person(s) you informed:

6. Date you were terminated, not hired, denied a promotion, denied an accommodation, or other adverse employment action:

7. Do you need any accommodations for this job? Y/N

a. Did you receive any accommodations for this job?

8. Have you filed a charge of discrimination with the Equal Employment Opportunity Commission or the Pennsylvania Human Relations Commission? Y/N

a. If yes, which agency?

b. Date you filed your charge

c. Status of your charge: what has the agency done so far?

e.g. was a fact finding conference held?

d. Please provide a copy of your charge and any correspondence from the agency.

**SECTION IV: YOUR CASE**

What happened?

Please complete ONLY the sections that apply to your case. If a section does not apply to your case, please skip it and go to the next section. You may attach additional sheets is needed to complete your response.

**Section A. Reasonable Accommodation**

**Do you need an accommodation to perform the essential functions of your job?**

Only complete if you need an accommodation or were denied an accommodation

1. What accommodation do you think you need? You can write “I don’t know” if you’re not sure.

2. What job tasks are difficult for you to do without accommodations?

3. How would accommodations help you perform those tasks?

a. Have you had these accommodations at other places?

4. Have you asked for an accommodation? Y/N

a. Name of the person you asked:

b. Most recent date you made the request:

c. What was the response?

d. Did you ask in person, over the phone, in an email, or in writing?

i. Do you have a copy of the email or letter?

5. Do you need advice on how to ask for and get an accommodation? Y/N

6. Have you been provided any other accommodations for this job? Y/N

7. Please provide all correspondence about your accommodation request: any emails, letters, or voicemails about your request

**Section B. Failure to hire or failure to promote**

**Did you apply for a job or a promotion and were not hired because of your disability?**

If no, do not complete this section.

If yes, please answer each question as specifically as possible. If you do not know the answer, please write that you do not know.

1. Date you applied for the job:

2. How did you apply for the job? Online, in person, on paper?

a. Do you have a copy of the job application? Please provide it.

3. Did you have an interview?

a. Names and job titles of all the people who interviewed you:

4. Did the employment application or interview ask you any questions about your disability? Y/N

a. What was the question?

5. Did you take any tests to apply for the job? Y/N

e.g. typing test or physical strength test?

a. If yes, what test(s)?

b. Were any accommodations provided for those tests?

6. Was someone else hired for or promoted to the job? Y/N

a. Do you know whether that person had a disability? Y/N

b. Do you know the name of that person?

7. Why do you believe the decision was based on your disability?

**Section C. Terminated or demoted on basis of disability**

**Were you terminated or lost a position or pay/hours because of your disability?**

If no, do not complete this section.

If yes, please answer each question as specifically as possible. If you do not know the answer, please write that you do not know. You may include additional explanation on a separate sheet.

1. Date you terminated, demoted or denied pay/hours:

2. If you were demoted or denied pay/hours,

a. What was the original job title and salary/hours:

b. What is your current job title and salary/hours:

3. Name of the person(s) who hired you:

4. Name of the person(s) who fired/demoted/reduced pay/hours:

5. What were the reasons given?

6. Did you ever receive evaluations? Y/N

How often?

Were they favorable?

Were any of them critical?

7. Did you ever receive any awards, special bonuses or recognition at work?

8. Have you ever been disciplined or received any warnings at this job?

a. For each time you were disciplined or warned, please give the:

Dates

Kind of discipline

Reasons

9. If you were terminated, would you like your job back? Y/N

10. Why do you believe the decision was based on your disability?

**SECTION V: REFERRAL**

1. How did you find this intake form?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Did someone refer you to this project?

a. If yes, what organization referred you?