GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Frank W. Berry, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Katie Beckett Team ADA Reasonable Modification and Communication Assistance Request Form for Persons with Disabilities

Do you have a disability and need a reasonable modification or communication assistance to access Katie Beckett services?

To request a reasonable modification, communication assistance, or extra help, please complete the form below. You are not required to complete this form or tell us your disability in order to receive reasonable modifications, communication assistance, or extra help.

If you need help completing this, please ask one of our staff members or call 678-248-7449. Alternative formats of this form are available upon request. The information you give us is confidential.

The DCH Katie Beckett Team provides:

- Reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change operating policies, practices, or procedures to provide equal access;
- Persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters, for effective communication.

DCH is not required to make any modifications that would result in a fundamental alteration in the nature of a service, eligibility or level of care requirements, or create undue financial and administrative burdens.

DCH is prohibited from disclosing Personally Identifiable Information (PII) or Protected Health Information (PHI) to unauthorized individuals. Therefore, DCH will not disclose, discuss or allow access to the PII or PHI of the person with a disability without the appropriate authorization.

In situations where a companion or other individual requests a reasonable modification or communication assistance on behalf of a person with a disability, DCH will contact the applicant/recipient with a disability or authorized representative to verify the request.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

For Agency Use Only

Head of Household_____ **Client ID** _____

Date: _____

Name of the person with a disability who needs a reasonable modification, communication assistance, or extra help:

_____

***Requestor's Name (if different from the name listed above):** __ _____

Relationship of requestor to person with a disability: _____

Phone No.:_____ **Email:** _____

Date of birth of person with disability: / / or Client ID: _____

Address: Street_____ **City**_____ **Zip**_____

County: _____ **Phone No.:**_____

Email (if available): _____

Program (Check all that apply): ___ Medicaid ___ PeachCare for Kids®

1. Do you need a reasonable modification (extra help) due to a disability?

   ___Yes ____No

   If yes, please describe the reasonable modification that you are requesting.

_____
_____
_____

2. Do you or your companion need communication assistance because of a disability? If yes, please tell us so that we can assist you. (Select all that apply)

   Sign Language interpreter ___; Cued Speech Interpreter___ ; Oral Interpreter ___; Tactile Interpreter ___; TTY ____; Braille ____; Large Print ____; Electronic communication (email) ____; Other:_____

3. How will this reasonable modification (or extra help) assist you?

_____
_____
_____

Name of Person with Disability:_____ Date of Birth or Client ID_____

4. Do you need this reasonable modification, communication assistance, or extra help **one-time ____ or ongoing ____?** If possible, please explain when and how long you need this assistance (extra help)?

_____
_____
_____

Please give this completed form to your caseworker, the person at the front desk, or email to constituentservices@dch.ga.gov and write "ADA" in the subject line.

*Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.

Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

For Agency Use Only:

Client ID: _____

Date RM Form Received by DCH: _____

Was the RM Form on behalf of a person with a disability? Yes___ No ___

Received by: _____ _____
Staff Name Title

Action Taken by: _____ _____
Staff Name Title

Action Completed:

_____
_____

Date Action Completed: _____

NOTE: A request for Reasonable Modification (extra help) may only be denied by the DCH Deputy Executive Director of Eligibility & Enrollment or his/her designee.