GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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.

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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): _____

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 mail to:

Katie Beckett Team ADA/Section 504 Coordinator
2211 Beaver Ruin Road, Suite 150
Norcross, GA 30071

or email to dch.adarequests@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, or religion.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Additionally, program information may be made available in languages other than English.

Any person or representative for a Katie Beckett applicant or participant may file a verbal or written complaint alleging unlawful discrimination by contacting the DCH Civil Rights Coordinator, Policy, Compliance and Operations Office, Medical Assistance

Plans Division, DCH at (local) 404-967-0401, or via email to DCH.CivilRights@dch.ga.gov, or via U.S. mail to:

The Georgia Department of
Community Health DCH Civil Rights
Coordinator
Policy, Compliance and Operations
Office Medical Assistance Plans
Division
2 Peachtree Street, NW
37th Floor
Atlanta, GA 30303

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 SW, Washington, D.C. 20201,

or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

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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 the Policy, Compliance and Operations Office of Medical Assistance Plans or his designee.