DEPARTMENT OF CORRECTIONS

INCARCERATED PERSON/RESIDENT REQUEST FOR MODIFICATION

Instructions: Please fully complete form, attaching additional pages if necessary, and send this form to the Facility ADA Coordinator. If you need help completing or submitting this form, please ask the facility ADA coordinator or another staff person.

Name:	OID:
Facility:	

1. Describe your disability/condition:

2. How does your disability/condition limit your daily activities and ability to participate in services, activities, and programming at the facility?

3. What modifications, aids or services, or accommodations are you requesting for your disability/condition to help you to participate in or benefit from DOC programs, services, or activities?

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By submitting this form, I agree to participate in discussions, assessments, or examinations with correctional, medical, or behavioral health staff as necessary in an effort to resolve this request. The Minnesota Department of Corrections is requesting this information for purposes of evaluating your request for disability-related accommodations, modifications, auxiliary aids or services. You are not legally required to provide this information, but if you do not do so, the DOC may be unable to determine whether disability-related accommodations, modifications, auxiliary aids or services are appropriate. Individuals who will have access to this data are DOC staff whose work assignment reasonably requires access. This data may be otherwise disclosed to those authorized access by law or pursuant to court order.

_____ _____

Incarcerated Person's/Resident's (or Guardian's) Signature Date

Received by:

_____ _____

Employee Signature/Printed Name Date

Facility ADA coordinator:

Date(s) of meeting with requestor: _____

Temporarily-approved request: _____

_____

Date of the facility ADA committee when the request will be considered:

_____

_____ _____

Signature/Printed Name Date

Copies: COMS, requestor, and facility ADA committee