DEPARTMENT OF CORRECTIONS

INCARCERATED PERSON'S/RESIDENT'S APPEAL OF ADA DECISION

Incarcerated Person's Resident's Name:	**OID:**
Facility:	

I requested accommodations, modifications, and/or auxiliary aids or services and I am appealing the Facility ADA Committee's decision because:

☐ My request for accommodations, modifications, or auxiliary aids or services was denied, but I believe it should have been granted.
☐ Other accommodations, modifications, or auxiliary aids or services were approved, but I believe the ones I requested should have been granted.
☐ I disagree with the Facility ADA Committee's conclusion that I do not have a disability.
☐ I disagree with the Facility ADA Committee's conclusion that I do not qualify for accommodations, modifications, or auxiliary aids or services due to my disability.
☐ Other *(explain)*:

Please provide any additional information you would like the ADA Compliance Coordinator to consider *(attach additional pages if necessary)*:

Signature: _____ Date: _____

DEPARTMENT OF CORRECTIONS

Submit your appeal by U.S. mail to the DOC ADA Compliance Coordinator at DOC Central Office within thirty (30) days of the decision you wish to appeal.

You must attach the following documents to this appeal form before mailing it to the DOC ADA Compliance Coordinator:

(1) Your Request for Modification form; and

(2) The written response you received from the facility ADA committee.

The DOC ADA Compliance Coordinator will respond to your appeal within fifteen (15) working days of receiving it.