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:

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| ☐ 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)*:

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Signature: _____ Date: _____

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***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.***