

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

<b>Incarcerated Person's Resident's Name:</b>	<b>OID:</b>
<b>Facility:</b>	

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

<input type="checkbox"/> My request for accommodations, modifications, or auxiliary aids or services was denied, but I believe it should have been granted.
<input type="checkbox"/> Other accommodations, modifications, or auxiliary aids or services were approved, but I believe the ones I requested should have been granted.
<input type="checkbox"/> I disagree with the Facility ADA Committee's conclusion that I do not have a disability.
<input type="checkbox"/> 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.
<input type="checkbox"/> Other ( <i>explain</i> ):

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: \_\_\_\_\_

***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.***