

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 fac		
3. What modifications, aids or services, or accommodisability/condition to help you to participate in or services, or activities?		



By submitting this form, I agree to participate in discussions, with correctional, medical, or behavioral health staff as neces this request. The Minnesota Department of Corrections is requirposes of evaluating your request for disability-related account auxiliary aids or services. You are not legally required to proviou do not do so, the DOC may be unable to determine wheth accommodations, modifications, auxiliary aids or services are will have access to this data are DOC staff whose work assign access. This data may be otherwise disclosed to those authorito court order.	sary in an effort to resolve uesting this information for ommodations, modifications, vide this information, but if ner disability-related appropriate. Individuals who ment reasonably requires
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	

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