DFCS Reasonable Modifications and Communication Assistance Request Form for Persons with Disabilities

Do you have a disability and need a reasonable modification or communication assistance to access DFCS’s services?

To request a reasonable modification, communication assistance, or extra help, please complete the form below. You are not required to complete this form or tell us your disability in order to receive reasonable modifications, communication assistance, or extra help.

If you need help completing this, please ask one of our staff members or call 404-657-3433. Alternative formats of this form are available upon request. The information you give us is confidential.

DFCS provides:

- Reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access;
• Communication assistance for persons with disabilities or their companions with disabilities, such as sign language interpreters, for effective communication.

DFCS is not required to make any modifications that would result in a fundamental alteration in the nature of a service, program or activity or in undue financial and administrative burdens.

DFCS is prohibited from disclosing Personally Identifiable Information (PII) or Protected Health Information (PHI) to unauthorized individuals. Therefore, DFCS will not disclose, discuss or allow access to the person with a disability’s PII or PHI without the appropriate authorization.

In situations where a companion or other individual requests a reasonable modification or communication assistance on behalf of a person with a disability, DFCS will contact the applicant/recipient with a disability or authorized representative to verify the request.
Date: ____________________

Name of the person with a disability who needs a reasonable modification, communication assistance, or extra help:

_________________________________________________________

*Requestor’s Name (if different from the name listed above): _______________________

   Relationship of requestor to person with a disability: __________________

   Phone No.: _______________________

   Email: ____________________________

Date of birth of person with disability: _____/____/____ or

Client ID: ________________________

Address: Street________________________

City_____________ Zip________________

County: ______________

Phone
No.: _______________________

Email (if available): ____________________________
Name of Person with Disability

______________________________________________________________

Date of Birth or Client ID______________

Please check the DFCS program(s) that apply: ___
SNAP _____ TANF ___ Medical Assistance (e.g., Medicaid and PeachCare for Kids®) _____ Child welfare (CPS, foster care, adoption, family reunification) Other: ______________________

1. Do you need a reasonable modification because of a disability?
   ___Yes  _______ No

   If yes, please describe the reasonable modification that you are requesting.

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Name of Person with Disability

______________________________________________________________

Date of Birth or Client ID

2. Do you or your companion need communication assistance because of a disability? If yes, please tell us so that we can assist you. (Select all that apply)
   Sign Language interpreter ___;
   Cued Speech Interpreter ___;
   Oral Interpreter ___; Tactile Interpreter ___;
   TTY ___; Braille ___; Large Print ___;
   Electronic communication (email) ___;
   Other: ____________________

3. How will this reasonable modification or communication assistance (or extra help) assist you?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

4. Do you need this reasonable modification, communication assistance, or extra help one-time _____ or ongoing _____? If possible, please explain when and how long you need this assistance (extra help)?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
RETURN THIS FORM TO:

your caseworker, the person at the front desk, or email to: Customer_services_dfcs@dhs.ga.gov and write “ADA” in the subject line.


See the U.S. Department of Agriculture and U.S. Health and Human Services nondiscrimination statement on the next page.
Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.