# Department of Public Health

## Americans with Disabilities Act (ADA)

## **Request for Reasonable Modifications**

In accordance with the requirements of Title II of the Americans with Disabilities Act of 1990 ("ADA"), the Los Angeles County Department of Public Health (Public Health) will not discriminate against qualified individuals with disabilities on the basis of disability in its services, programs, or activities.

If you are a qualified individual with a disability that needs a reasonable modification, you or your authorized representative may submit the attached request form to a Public Health employee in the location of service of your interest, or you may contact the Public Health ADA Compliance Coordinator at:

ADA Compliance Coordinator
5555 Ferguson Drive, Suite 3033
Commerce, CA 90022

Telephone: (844) 914-1006
Email: DPH-ADA@ph.lacounty.gov

California Relay Service (Free) Dial 7-1-1 to be connected

**Note: You are not required to complete this form to request a reasonable modification and may ask Public Health employees for assistance with access to services. However, completion of the form allows us to better track and ensure timely processing of your request. You may ask someone else (companion, member of your care team, other person that you designate) to fill out this form for you and communicate with DPH employees about your requested modifications.**

**Note to Public Health employees:** You must direct all requests for modifications (i.e., assistance with access to services/facilities) to the ADA Compliance Coordinator. This directive does not include language assistance services, which are coordinated by the designated Department Service Category Managers (DSCMs): http://intranet.ph.lacounty.gov/ph/PDFs/ContractsAndGrants/DPHDepartmentServiceCategoryManager.pdf

*This Form and Related Materials Are Available in Alternate Formats and Languages, Upon Request*

## Americans with Disabilities Act (ADA)
## Request for Reasonable Modifications

Last Name | First Name | MI

Home/Mailing Address

City | State | Zip

Phone | Email Address:

**What do you need help with? (Check all that apply)**

☐ Written communications ☐ American Sign Language (ASL) ☐ Hearing

☐ Mobility ☐ Scheduling an appointment ☐ Filling out forms

Other:

**Date and Time Modification(s) were Requested:**

*Date:_____, Time:_____am/pm*

How would you like to be informed about the status of your request for modification?

☐ Phone ☐ Mail ☐ Email ☐ Other: _____

**Participant Signature:** **Date:**

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**Designee Authorization:**

If you want to allow the Department of Public Health to discuss your disability/request for accommodation/modification with them, someone else on your behalf (your designee), we need your approval. Please fill out the section below and sign.

I authorize _____
(Print Name of Designee)

From _____ To _____
(First Date Designee is Authorized) (Last Date Designee is Authorized)

| Requestor Signature | | Date |
|---|---|---|
| Print Designee Name (If applicable) | Relationship to Requestor | Telephone No. |
| | | |
| Address | City and State | Zip Code |
| E-Mail Address | | |

**FOR DEPARTMENT OF PUBLIC HEALTH'S USE**

Date Request Received: Received By:

Decision: ☐ Granted ☐ Denied

Explanation:

Decision made by:

For requests received and denied by program staff, was the ADA Compliance Coordinator consulted?

☐ Yes ☐ No

If no, explain why?

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