APPENDIX J

REQUEST FOR AUXILIARY AID (CONFIDENTIAL)
UNDER TITLE II OF THE AMERICANS WITH DISABILITIES ACT, AS AMENDED

DEPARTMENT OF HUMAN SERVICES
CLIENTS AND APPLICANTS FOR SERVICES, PROGRAMS AND ACTIVITIES

Date of Request: _____

Please Check One: ☐ Applicant ☐ Client

Requester's Name: _____

Program/Activity or Service: _____

Division/Section/Unit: _____

Mailing Address: _____

Day Phone: _____

APPLICATION
(To be completed by client/applicant)

1. I am requesting the following auxiliary aid(s): _____

2. It is necessary for me to have this auxiliary aid(s) for the following reasons:

Requester's Signature: _____ Date: _____

For INTERNAL USE ONLY
DETERMINATION

Your request of _____ for an auxiliary aid(s) has been:
(Date of Request)

☐ Approved AUXILIARY AID(S) PROVIDED: _____

☐ Disapproved REASON(S) DENIED: _____

☐ Approved with Modification: _____

☐ Approved for Trial Period from: _____ to: _____

Comments: _____

If you disagree with this determination, you may present additional information to further substantiate your request by contacting Geneva Watts, Civil Rights Compliance Officer, at 586-4955 or via gwatts@dhs.hawaii.gov.

REQUEST FOR AUXILIARY AID
General Instructions

This form is meant to simplify the processing and recording of requests for auxiliary aids for Department of Human Services' clients and applicants for services who quality under the Americans with Disabilities Act, as amended.

General Information: To be completed by DHS Client or Applicant for DHS Services

Date of Request: Enter the date the request is made.

Please Check One: DHS Client or Applicant for Services

Requester's Name: Self-explanatory. Name the requester is using for services with DHS.

Program/Activity or Service: For example: SNAP, EBT Card, Nutrition.

Division/Section/Unit: Enter location where services are provided.

Mailing Address: Enter place where mail can be received by Client or Applicant.

Day Phone: Enter a daytime phone number where Client or Applicant can be reached.

Application: To be completed by employee or applicant making request.

Requesting Auxiliary Aid(s):

1. Describe specifically what requester believes is needed. Provide photograph where applicable.
2. Reasons: Describe the functional limitations that make this request necessary.

Requester's Signature: Self-explanatory. Standard signature that is recognizable.

Date: Enter the date application is signed by the requester.

Questions: Case worker, client or applicant may contact the DHS ADA Coordinator, gwatts@dhs.hawaii.gov or (808) 586-4955.

PLEASE PROCESS IMMEDIATELY. DELAY IS SOMETIMES DENIAL.

Determination: To be completed by Case Worker or Supervisor.

Date of Request: Enter date requester signed.

Approved: Accommodation(s) provided (for example: specific cost, dates, item(s), etc.)

Disapproved, Reason(s) Denied: When all or part of the request is denied, state specifically what is disapproved and reason(s) for disapproval.

Approved with Modification: When request is modified, state specifically how it differs from the original request and reason(s).

Approved for Trial Period: Enter start date and end date with comments relative to why the trial period is approved.

PLEASE PROCESS IMMEDIATELY. DELAY IS SOMETIMES DENIAL.

FOR INTERNAL USE ONLY

Date Request Received in PERS/CRCS with Backup*: _____

Final Decision: _____

Date of Final Decision: _____

Action Taken: _____

Comments: _____

Signature: _____

ADA Coordinator/Civil Rights Compliance Officer

Date Notice Sent: _____

***Important Note to Case Workers and Supervisors**

It is important for the immediate supervisor to meet with the client or applicant for DHS services requesting accommodation to discuss the request, which is called the interactive process. More than one meeting is usually necessary. The case worker or supervisor must document the meeting date(s) and time(s), listing those present with specific information about functional limitations, accommodation alternatives considered and specifically what is being approved, disapproved with reason(s), modified with reason(s), and/or trial period being recommended.

An ICF from the immediate supervisor of the program/service through channels (with initials and date(s) signed) to PERS/CRCS with specifics and photographs (where applicable), dates and times of discussion(s) with requester, estimated costs and timeframes, relationship to the services being provided, along with the original, signed request (Request for Auxiliary Aid) is needed prior to processing.