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: __________

INTERNAL USE ONLY - DETERMINATION

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

☐ 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 your case worker or the DHS/Civil Rights Compliance Staff, via email at DHSCivilRightsBox@dhs.hawaii.gov or call (808) 586-4955.

PROVIDE A COPY OF THE COMPLETED FORM TO THE HUMAN RESOURCES OFFICE, CIVIL RIGHTS COMPLIANCE STAFF

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 making request.

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, vocational services, medical insurance, etc.

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 DHS client or applicant for DHS services making request

Requesting Auxiliary Aid(s):

1. Describe specifically (for example: make, model, photograph, etc.) what requester believes is needed

2. Reasons: Describe the functional limitations that make this request necessary

Requester's Signature: Self-explanatory

Date: Enter the date application is signed by the requester

Questions: Case worker, client, or applicant may contact the DHS ADA Coordinator via e-mail at DHSCivilRightsBox@dhs.hawaii.gov.

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.

*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 an auxiliary aid to discuss the request, which is called the interactive process. More than one meeting may be necessary. The case worker or supervisor must document the meeting date(s) and time(s), listing those present and specific information about functional limitations, auxiliary aid alternatives considered and specifically what is being approved, disapproved with reason(s), modified with reason(s), and/or trial period being recommended.