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 (DPH) will not discriminate against qualified individuals with disabilities on the basis of disability in its services, programs, or activities. The law requires DPH to provide reasonable modifications to individuals with a disability.

We can give persons with disabilities the extra help they need or modify some program requirements and practices.

If you are a qualified individual with a disability that needs a reasonable modification, you can submit the attached request form to any DPH employee or you can ask any DPH employee for help.

You may also contact the DPH ADA Compliance Coordinator at:

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

Telephone: 1 (844) 914-1006
Email: DPH-ADA@ph.lacounty.gov

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

DPH will provide a response to your request or requests for modification within five (5) working days from the date the request was received.

Note: You are not required to complete this form to be provided a reasonable modification.

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Last Name First Name MI

Home/Mailing Address

City State Zip

Phone Email Address:

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

☐ Phone ☐ Writing ☐ Other: _____

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

☐ Reading
☐ Hearing
☐ Walking
☐ American Sign Language (ASL)
☐ Scheduling an appointment
☐ Filling out forms

_____

☐Other: Describe how we can help you. If you are not sure what modifications you need, please list any suggestions you may have about options we can explore *(Use additional sheet if necessary).*

_____

_____

All requests for accommodations/modifications will be evaluated individually and a response to your request will be provided within five (5) working days. If your request is time sensitive, please provide the specific date/time for your requested modification.

Time Sensitive: ☐ *YES requested for Date:_____, Time:_____am/pm* ☐ *NO*

_____ _____

Participant Signature Date

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

I authorize _____ Date _____

(Print Name of Designee)

This Notice and Related Materials Are Available in Alternate Format and Languages.

This request for reasonable modification with DPH is valid for a period of 30 days. I may revoke this authorization at any time except for information that has already been given to DPH.

This document will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had the form read to me) after it was completed. I know I can get a copy of this document if I ask for it.

Applicant/Participant /Signature		Date
Print Designee Name (If applicable)	Relationship to Applicant/Participant	Telephone No.
Address	City and State	Zip Code

All requests for accommodations/modifications will be evaluated individually and a response to your request will be provided within five (5) working days (or sooner if applicable).

DPH ADA Compliance Coordinator or DPH Staff Notes:

ADA Compliance Coordinator or DPH Staff (Print Name): _____ Date: _____

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