ADA ACCOMMODATION REQUEST FORM

FOR MEMBERS OF COLORADO ACCESS

If you need help completing this form, please contact us at:
Phone: 800-511-5010
TTY: 888-803-4494
Email: Member.ADA.Coordinator@coaccess.com
Mailing Address: 4643 S. Ulster St. Ste 700, Denver, CO 80237

INSTRUCTIONS: Type in the shaded fields; mark check boxes with an X.

SECTION 1: MEMBER INFORMATION

Member Name:	
Medicaid ID Number:	Date of Birth:
Phone Number:	Email (optional):
Contact name:	Phone:
Preferred Method of Contact: Email	If Other, specify:

MAILING ADDRESS

Street:		
City:	State: CO	ZIP:

SECTION 2: ACCOMMODATION REQUEST

Describe the accommodation you are requesting

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Explain how your disability makes this accommodation necessary (You do not need to share your diagnosis unless you choose to)

SECTION 3: TYPE OF ACCOMMODATION NEEDED (Select all that apply)

COMMUNICATION SUPPORTS

☐ Sign language interpreter
☐ Spoken language interpreter
☐ TTY or TDD services
☐ Relay services
☐ Communication in plain language
☐ Extra time during calls or appointments
☐ Other:

ALTERNATIVE FORMATS

☐ Large Braile
☐ Braile
☐ Audio Format
☐ Accessible electronic format (PDF, email, digital file)
☐ Other:

PHYSICAL OR ACCESS NEEDS

☐ Accessible meeting location
☐ Mobility assistance
☐ Help completing forms or applications
☐ Other:

OTHER ACCOMMODATION NEEDS

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SECTION 4: REPRESENTATIVE INFORMATION (If Applicable)

Representative Name:	Relationship to Member:
Phone Number:	Email:

SECTION 5: SIGNATURE

By signing below, I confirm that the information provided is true and that I am requesting an ADA accommodation to help me access my health plan services.

Signature: Date:

SECTION 6: HEALTH PLAN USE ONLY

Date Received:	Reviewed By:

Accommodation Approved ☐Yes ☐ No

If no, reason:

Accommodation Provided:

Date Member Notified: