ACD QUALIFICATION FOR SPECIAL ACCOMMODATIONS BASED ON DISABILTY FORM (CONFIDENTIAL)

DATE:

TO:	Name, Address and Fax number of Physician who is being requested to verify this information		FROM:	A CHILD'S DREAM – CA Attn: Cassandra Steptoe-Sampson 424-209-2352 info@achildsdream-ca.org

RETURN THIS VERIFICATION TO A CHILD'S DREAM-CA. (This is important because the nonprofit organization has a responsibility to treat this information confidentially.)

SUBJECT: Verification of Disability

NAME: _____

ADDRESS: _____

This person has requested special accommodation during A Child's Dream-CA Outreach events (Outreach). The Outreach is held indoors and outdoors and requires standing for long periods of time, limited to no seating, interaction with large crowds of people, optional lifting up to 50 pounds, and basic writing and communication skills. The Outreach does not tolerate discrimination or harassment at the Outreach event based on an individual's disability. In furtherance of this principle and in compliance with applicable laws, the Outreach provides reasonable alternatives to qualified individuals with disabilities unless the accommodation would impose an undue hardship on the operation of the Outreach's event or would change the essential functions of the event.

INFORMATION BEING REQUESTED: For each numbered item below, mark and "X" in the applicable box that accurately describes the person listed above.

1	☐YES ☐NO	Has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to participate during the Outreach independently, and is of a nature that such ability could be improved by more suitable accommodations.						
2	☐YES ☐NO	Is a person with a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)), i.e., a person with a severe chronic disability that: a. Is attributable to a mental or physical impairment or combination of mental and physical impairments; b. Is manifested before the person attains age 22; c. Is likely to continue indefinitely; d. Results in substantial functional limitation in three or more of the following areas of major life activity; (1) Self-care, (2) Receptive and expressive language, (3) Learning, (4) Mobility, (5) Self-direction, (6) Capacity for independent living, and (7) Economic self-sufficiency; and e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated						
3	☐YES ☐NO	Is a person with a chronic mental illness, i.e., he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to participate during the Outreach independently, and whose impairment could be improved by more suitable accommodations.						
4	Identify the major life activities that are limited due to the health condition(s), the treatment for the health condition, or the side effect of medication for the health condition that may influence these major activities.							
5	☐YES ☐NO	STANDING #HOURS_____	☐YES ☐NO	SITTING #HOURS_____	☐YES ☐NO	LIFTING #LBS_____		
6	☐YES ☐NO	WALKING #HOURS_____	ADDITIONAL MAJOR LIFE ACTIVITIES LIMITATIONS (CHECK ALL THAT APPLY.)		☐	SIGHT HEAR SPEAK	☐	CONCENTRATION INTERACT W/OTHERS
7	Explain Suitable Accommodations Needed for Outreach Participation: _____ _____							

Provider Name: (Print)_____Provider Signature:_____ Date:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION
With A Child's Dream-CA (Outreach) and Disability Services Representative (DSR)

I, _____am requesting Special Accommodations based on disability during A Child's Dream-CA Outreach event.
I hereby authorize (Medical Provider_____ of (Clinic)_____
To discuss, disclose, and/or deliver to Outreach and DSR via electronic mail at: info@achildsdream-ca.org,the following specific information pertaining to:

Applicant Name: _____
Birthdate:_____ Telephone(H)_____(Cell)_____

The following released information will be used for the purpose of determining special accommodation needs during the Outreach event.
(check and initial applicable information)

☐	_____	MEDICAL
☐	_____	PSYCHIATRIC
☐	_____	PSYCHOLOGICAL
☐	_____	OTHER: (Explain)
I understand that this information will include (check and initial, if applicable):		
☐	_____	Acquired Immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
☐	_____	Behavioral health serviced/psychiatric care.
☐	_____	Treatment for alcohol and/or drug abuse.

Affirmation of Release: I give or the named agency permission to release only the information I have selected on this form to the individuals I have named and only for the purpose identified. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand any action on my part to deny access to information that is essential to the determination of reasonable accommodation(s) may nullify the accommodation process and influence employment decisions. The revocation will take effect on the day it is received in writing. I further understand that the members of A child's Dream-CA and Disability Services Representative receiving this information are not health care providers, a health plan or health care clearinghouse and may not be covered by the federal privacy regulations.

Applicant Signature: _____ Date: _____

Authorized Signature: _____Date: _____
(Relationship to Applicant)