**REQUEST FOR AUXILIARY AIDS/SERVICES**

**FOR EFFECTIVE COMMUNICATION**

Client Name: Case ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Aid(s)/Service(s) preferred:

[ ]  ASL Interpreter

 [ ]  Certified Deaf Interpreter

 [ ]  Personal listening device

 [ ]  C.A.R.T.

 [ ]  Materials in written format

 [ ]  Materials in large print

 [ ]  Materials in audio format

 [ ]  Braille teletouch

 [ ]  Braille format

 [ ]  Note taker

 [ ]  Qualified reader

[ ]  Other type of aid/service (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_** Initial here if you prefer to provide your own interpreter or other auxiliary aid/service. However, Nevada Rehabilitation Division can not ensure the quality or provision of effective communication when you choose to use your own aids. You may subsequently request and elect to use auxiliary aids provided by the Division any time during your case.

 *If your preferred auxiliary aid or service changes, you agree to notify your Rehabilitation Counselor and complete a new form.*

**If your preferred auxiliary aid/service request is denied by the Division, you will receive official notification. You also have the ability to appeal the decision by contacting the Client Assistance Program (see the attached Determination Disagreement Statement).**

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rehabilitation Counselor Printed Name & Signature Date

Enclosure: Determination Disagreement Statement