Updated 01/2024

Alabama Department of Mental Health
Office of Deaf Services

Notification of Right to Free Language Assistance

for individuals who are Hard of Hearing

(This form must be presented in a format the consumer can easily understand. This usually means the consumer's preferred language)

Verbiage should not be changed below this line.

Case #_____ Provider/Center Name_____

I, _____, am a Hard of Hearing individual who may use English in an atypical format (such as lipreading, captioning, written format, etc.). I do not use sign language as my primary mode of communication.
**If sign language is utilized as a preferred/primary mode of communication, see NOFLA for Deaf form.*
**If a language other than English is utilized as a preferred/primary mode of communication, see NOFLA for Spoken Language*

I have been informed that it is important for my care to receive the services in the language that I understand best (my language of preference) and/or in a communication modality which is most readily understandable. I have been advised that the Alabama Department of Mental Health (ADMH) is willing and can provide, at no cost to me appropriate accommodations. I have decided:

☐ I am a hard of hearing or a deaf person and want to work with a clinical service provider utilizing the following accommodations (***please specify below****):

☐ Lip reading/speechreading/residual hearing with the following accommodations (preferential seating, maintained eye contact, reduced ambient noises, speech directed to better ear, increased volume, appropriate lighting, appropriate turn taking and identification of speaker, etc.)

***Please specify preferred accommodations as mentioned above**_____

_____

☐ Oral Transliterator

☐ Cued Speech Transliterator

☐ Written English, which may include the following methods (CART, C-print, typed via computer, Ubi-Duo, voice recognition software, handwritten notes, access to written materials, etc.)

***Please specify preferred accommodations as mentioned above**_____

_____

☐ Other, please specify: _____

☐ I am a Hard of Hearing individual and I prefer to use the following person to provide accommodations for me as indicated above: _____. I agree not to hold my clinical service providers, ADMH or its contract programs responsible for any adverse results that may arise from using this person. (This person cannot be a younger than 18 years old, this includes family members.) The agency or the ADMH Office of Deaf Services may determine that the person is not able or appropriate to perform this function. In such cases, the person mentioned above may remain as a support system.

☐ I do not want free language/communication assistance provided by ADMH as mentioned above. I agree not to hold my clinical service provider or any other personnel at ADMH or its contract programs responsible for any adverse consequences that may arise as a result of my decision.

I understand that if my treatment team requests an accessibility accommodation provided by the ADMH, it will be provided for them. I also understand that I can change my mind at any time. This waiver will expire one (1) year from the date signed. I understand that I may change my selection at any time by completing a new waiver.

_____	_____	_____
Signature of Consumer	Signature of Parent or Guardian (if applicable)	Date
_____	_____	
Signature of Provider	Witness	

Note: Every effort should be made to assure that the consumer fully understands his or her right to accessible communication in their language of preference and that such assistance will be provided at no charge. A provider who does not share the preferred language of the consumer does not meet the standards of this notification. Pursuant to Title VI requirements this document is to be filed in the consumer's permanent file and a copy given to the consumer.