ADM

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.
All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*	**YES**	**NO**
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.* I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

Primary Spoken Language: _____
Patient's preferred language for discussing healthcare: _____
Interpreter services are available 24 hours per day.
Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members of friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.
Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.
Call 1-219-983-8300 (TTY: 1-800-743-3333).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-219-983-8300 (TTY: 1-800-743-3333).

該供應商遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-219-983-8300（TTY：1-800-743-3333)。

Patient/Family Member/Companion Signature	Date/Time
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time
Witness	Date/Time

Patient Label