Carolina Family Health Centers, Inc.

Request for Accommodations

Carolina Family Health Centers Inc. provides patients with disabilities reasonable accommodations to assist them when they are seen at our office. We ask that you provide us with information to learn more about your needs. The information you provide will remain confidential. A staff member will reach out to you to learn more about how we can assist you upon receipt of the form. We cannot guarantee we can accommodate your request. Each request will be considered individually and tailored to meet individual needs. Carolina Family Health Centers, Inc. will work to try to find a reasonable alternative if necessary.

Patient Name: _____
Last *First* *Middle*

Date of Birth: _____/_____/_____ Email: _____
MO *DAY* *YR*

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

Preferred method of communication (circle at least one): Phone Text Email

Please indicate the type of disability that needs assistance. Please check all that apply:

- ☐ Visual Disability (blindness or low vision)
- ☐ Hearing Disability (deafness or hard of hearing)
- ☐ Memory Impairment
- ☐ Mobility Impairment
- ☐ Communication Disability
- ☐ Intellectual Disability
- ☐ Autism
- ☐ Speech Disability
- ☐ Major Mental Illness
- ☐ Other type of impairment or disability. Please explain: _____

Please explain the accommodations requested:

_____

_____

_____

_____

_____

Additional information:

Name of person completing this request if different form the patient.

Name (printed)_____

Signature: _____ Date: _____

Requests for accommodations can be sent to:

Carolina Family Health Centers, Inc.
Corina Buzard, Compliance Officer
303 Green Street East
Wilson, NC 27893

CFHCCompliance@cfhcnc.org