

COVID-19 Disability Accommodation Form

I am a person with a disability. Please read this form before you help me. This form will provide you with information you need in order to give me medical treatment.

MY NAME IS: _____

I LIKE TO BE CALLED: _____



I communicate by: (check all that you use)

- Talking Texting/Writing Pictures
 Sign Language Pointing to Words Using a Device

If you do not understand me, please call:

Name: _____ Phone: _____

Name: _____ Phone: _____

My Doctor's Name: _____ Phone: _____

My typical reaction to medical care is:

- Cooperate Scared Resist Confused
 Try to stop what you are doing

I do not like it when doctors or nurses: (Describe)

I like it when doctors or nurses: (Describe)



Allergies:

Current Medications I Take:

Medical Problems I see my Doctor for: (diabetes, heart problem, seizures, smoking etc.)

When I am in pain I:



I might get upset by: (lights, smells, being touched etc.)

If I am upset, the best way to help me:

Why should I fill out this form?

We are worried that a lot of people will get the Coronavirus at the same time. Your hospital may have too many people to help. They may say you cannot have any visitors. Talk to your team. Think about what support you need if you must stay in the hospital.



Tell the hospital staff, "I am a person with a disability, I have this form to help you understand how to help me."

- I can stay on my own in the hospital.
- I can stay on my own in the hospital with phone support from:

Name: _____

Phone: _____

(I need this person to support me by phone when getting medical updates, or making decisions)

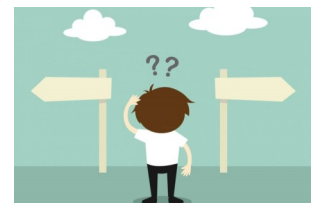
- I cannot stay on my own in the hospital. I need help to communicate, advocate, understand, make decisions and self-care.

I get this support from:

Name: _____

Phone: _____

(CARES Act Section 7715 allows direct care workers who provide Medicaid waiver services and other trained caregivers to assist people with disabilities in the hospital.)



If you think your civil rights are being violated, call Disability Rights Maine (DRM). **800.452.1948**

Leave a message with:

*Your Name

*Phone Number

*Room Number

*Hospital or Healthcare Facility you are at

Someone from DRM will contact you back as soon as possible.

**DISABILITY
RIGHTS
MAINE**

Giving Consent for Medical Care:

- I am my own guardian.
- I have a guardian.
- I have a supported decision making team.
- Other: _____



Please contact this person if necessary:

Name: _____ Phone: _____

To learn more about Speaking Up For Us Contact Us: Phone (207) 956-1004
Email programsufu@sufumaine.org Website: sufumaine.org

