TRI-COUNTY COMMUNITY COUNCIL, INC. REASONABLE ACCOMMODATION REQUEST FORM	
Name: Address: Telephone: E-mail:	
What type(s) of disabilities prevent you from using Tri-County Community Council, Inc. transportation services? (physical, developmental, visual impairment/blindness, mental illness, other)	
Is the disability described above temporary or permanent? If temporary, how long?	
What mobility aids do you use?	
Do you have a Personal Care Assistant that will be traveling with you?	
What specific accommodation are you requesting?	
If you are not sure what accommodation is needed, do you have any suggestions on what changes could be made that would allow you to utilize transportation services? If yes, please explain.	
Determination – Staff Use Only	
Is the modification needed for the person to fully benefit from the transportation service? Yes ☐ No ☐	
Does the modification fundamentally alter the nature of the service? Yes ☐ No ☐	
Does the modification create a direct threat to the health and safety of others? Yes ☐ No ☐	
Modification Granted? Yes ☐ No ☐	Reason for denial
Type of modification N/A ☐ Permanent ☐ Temporary ☐	If temporary, how long is modification needed?
If modification not granted, are there any options available that would allow the customer to use the service without compromising the nature of the service or causing harm to others?	
If yes, provide explanation.	
Method the requestor is notified of the decision and additional actions proposed, if any.	
Signature – Executive Director/ADA Coordinator	Date

If you need more space, attach additional sheet(s) and any other documentation that would assist us in meeting your request for Reasonable Accommodation.