COVID-19 Disabilty 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:** ______________________

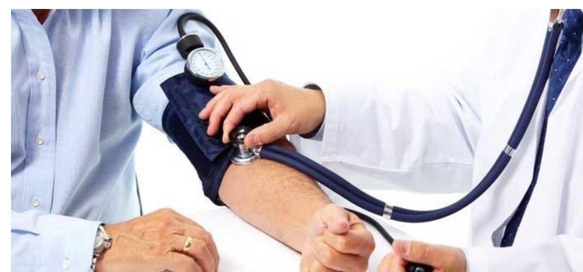
Name: ______________________________ **Phone:** ______________________

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)

____

____

Allergies:

____

____

____

I like it when doctors or nurses: (Describe)

____

____

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:

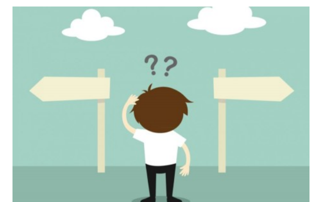
____

Why should I fill out this form?

We are worried that a lot 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**

DISABILITY RIGHTS MAINE

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.

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

This form was adapted by Speaking Up For Us from Green Mountain Self-Advocates from Ballan, M. & Perri, C. (2020). COVID-19 Disability Form. Stony Brook, NY and Perkins, E.A. (2011) My Health Passport for Hospital/Clinic Visits. FL Center Inclusive Communities