Broward Regional Health Planning Council
Substance Abuse and Mental Health Forensic Prorgram
Auxiliary Aids Plan

Broward Regional Health Planning Council (hereinafter referred to as BRHPC) shall comply with Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, as implemented by 45 C.F.R. Part 84 (hereinafter referred to as Section 504) and the Americans with Disabilities Act of 1990, 42 U.S.C. 12131, as implemented by 28 C.F.R. Part 35 (hereinafter referred to as ADA).

This plan will be available in alternative formats at the request of staff and participants. This plan will be disseminated to persons and agencies working with people living with a disability and people who are Limited English Proficient and will be posted on BRHPC's website.

Single Point of Contact

The Single Point of Contact, (Jenysset Pi, Natasha Markman, Jean Robert Menard) will ensure effective communication with Deaf or Hard-of-Hearing customers or companions in accordance with Section 504 and the ADA. Customers refer to clients and applicants. The Single Point of Contact shall ensure that employees are aware of the requirements, roles, responsibilities, and contact points associated with compliance with Section 504 and the ADA.

Provision of Auxiliary Aids and Services

BRHPC will at all times recognize that the customer or companion's preference is the primary consideration in determining what auxiliary aids or services to provide. If communication through a specific auxiliary aid or service is deemed to be ineffective, staff will ask the customer or companion to determine a more effective auxiliary aid or service for communication. Documentation shall be made in the customer's file regarding the attempt to improve the effectiveness of auxiliary aids and services.

If a participant or companion is Deaf or hard-of-hearing, BRHPC's staff shall obtain auxiliary aids according to the communication assessment and requested services. All ASL interpreters' certifications shall be verified.

Staff that is unfamiliar with the auxiliary aid or service requested shall contact their Single Point of Contact (SPOC), 504/ADA Coordinator (Heather DePetro Civil Rights Officer) or their Supervisor, for assistance in locating appropriate resources to ensure effective communication with clients, customers and companions.

Provision of Interpreters in a Timely Manner

BRHPC staff shall provide interpreters for customers and companions who are Deaf or hard-of-hearing in a timely manner in accordance to the following standards:

> **Non-Scheduled Interpreter Requests:** For any emergency situation that is not a scheduled appointment, staff shall make an interpreter available as soon as possible, but in no case later than two hours from the time the customer or companion or staff requests an interpreter, whichever is earlier. If the situation is not an emergency, staff shall offer to schedule an appointment (and provide an interpreter where necessary for effective communication) as convenient to the customer or companion, but at least by the next business day.

Scheduled Interpreter Requests: For scheduled events, staff shall make a qualified interpreter available at the time of the scheduled appointment. If an interpreter fails to appear for the scheduled appointment, staff shall take whatever additional actions are necessary to make a qualified interpreter available to the customer or companion who is deaf or hard-of-hearing as soon as possible, but in no case later than two hours after the scheduled appointment.

Auxiliary Aids Documentation

The SPOC shall document the customer or companion's preferred method of communication and any requested auxiliary aids and services provided in the customer's program file. Documents and forms evidencing when and how provided auxiliary aids and services to customers or companions shall be retained within the customer's corresponding file for seven years. Forms include but are not limited to:

- Customer or Companion Assessment and Assessment and Auxiliary Aid and Service Record (Appendix A)
- Customer or Companion Request for Free Communication Assistance or Waiver (Appendix B)
- Customer or Companion Feedback form (Appendix C)

This documentation will continue to be kept for record keeping with the SPOC.

Denied Auxiliary Requests

Documentation, with supporting justification, must also be made if any request was not honored. BRHPC's Executive Director is the only person that can deny auxiliary aid requests made by a customer or companion. If a staff person is not familiar with an auxiliary aid request, please contact the SPOC for any information that you may need to secure this aid, but reiterate that the cost of any auxiliary aid is the responsibility of the agency and not the participant.

Referrals

If customers or companions are referred to other agencies, the provider must ensure that the receiving agency is notified of the customer or companion's preferred method of communication and any auxiliary aid or service needs. In order to accommodate this, BRHPC will ensure that the referral is desired by the participant and that he or she signs a Release of Information Form.

Customer Feedback Form

The provider shall distribute Customer Feedback Forms to customers or companions that are Deaf or hard of hearing and will provide assistance in completing the forms if requested by the customer or companion. The original Customer Feedback Form shall be maintained in the clients file and a copy of the Customer Feedback Form shall be kept in the Executive Director's office.

Documentation/Record Retention

Records relating to auxiliary aids and services provided shall be retained by each local office and the original document retained in the client or customer's file or records. All final requests for accommodations, along with relevant documentation, will be forwarded to the designated 504/ ADA Coordinator.

Signage

The Single-Point-of-Contact will ensure that conspicuous notices which provide information about the availability of appropriate auxiliary aids and services at no-cost to the deaf or hard-of-hearing customers or companions are posted near where people enter or are admitted within BRHPC locations.

The approved Notices can be downloaded through the Internet at: http://www.dcf.state.fl.us

Event Accommodations

BRHPC shall ensure accessibility to meetings, conferences and seminars to persons with disabilities, limited English proficiency, and Deaf or hard-of-hearing.

Staff Training

The staff shall receive training on how to provide auxiliary aids and services for persons with disabilities and limited English proficiency (LEP) within 60 days of commencing employment. BRHPC's staff shall receive an annual refresher training on auxiliary aids and services for persons with disabilities and limited English proficiency (LEP). Training documentation shall be maintained in each employee's training file.

Auxiliary Aid Resources

Florida Video Relay – 7-1-1

Through the Florida Relay Service, people who use specialized telephone equipment can communicate with people who use standard telephone equipment. To call Florida Relay, dial **7-1-1**, or use the appropriate toll free numbers below:

1-800-955-8771 (TTY)
1-800-955-8770 (Voice)
1-877-955-8773 (Spanish)
1-877-955-8707 (French Creole)

Video Remote Interpreting

Through a video remote interpreter people can use an interpreter via technology to communicate with a participant instead of an in person interpreter. This is a good resource for emergency situations with limited time to get an in-person interpreter as well as if there are few local community resources for certified interpreters. Below is the phone number for the Registry of Interpreters for the Deaf which will provide contact information for certified video remote interpreting.

Registry of Interpreters for the Deaf: (703) 838-0030 (Video Remote)

Interpreters) CART-Captioning Real Time and Providers

Captioning (Real Time). This is the simultaneous conversion of spoken words to text, through computer-assisted transcription or court reporting, and displaying that text on a video screen. This communication service is beneficial to individuals who are deaf or hard-of-hearing that do not use sign language or for whom assistive listening devices and systems are ineffective.

LINK Translations &Typesetting, INC.
16560 NW 1st Street
Pembroke Pines, Florida 33028
(954) 437-0933

Coda Link, INC.
8963 Sterling Rd. Suite 6,
Cooper City, Florida, 33328
(954) 423-6893

Registry of Interpreters for the Deaf: (703) 838-0030

Florida Registry of Interpreters for the Deaf
www.fridcentral.org

Certified Sign Language Interpreters:

LINK Translations & Typesetting, INC.
16560 NW 1st Street
Pembroke Pines, Florida 33028
(954) 437-0933

Coda Link, INC.
8963 Sterling Rd. Suite 6,
Cooper City, Florida, 33328
(954) 423-6893

For Limited English Speaking Clients:

LINK Translations & Typesetting, INC.
16560 NW 1st Street
Pembroke Pines, Florida 33028
(954) 437-0933

Customer Complaints

If you believe you were wrongfully denied access to services or discriminated against:

1. Inform the person who denied access to services that you believe they wrongfully denied you services and why you believe that is the case.
2. Ask to speak to a manager, immediately.
3. You may submit your complaint/grievance in writing or verbally. Direct your concern to the Executive Director. Include the following information:
   a. What service were you denied?
   b. What were you told was the reason you were denied service?
   c. What person denied you services?
   d. What was the date you were denied service?

In addition,

Florida Department of Children and Families
Assistant Staff Director for Civil Rights
1317 Winewood Boulevard
Building 1, Room 110
Tallahassee, FL 32399-0700
850-487-1901

Executive Director
Florida Commission on Human Relations
2009 Apalachee Parkway, Suite 100
Tallahassee, FL 32301-4857
850-488-7082

US Department of Health & Human Services
Office for Civil Rights
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
404-562-7881

US Department of Justice
Coordination & Review Section
Civil Rights Division
P.O. Box 66118
Washington, DC 20035-6118
202-514-0301

APPENDIX A:
CUSTOMER OR COMPANION
COMMUNICATION ASSESSMENT
AND
AUXILIARY AID AND SERVICE RECORD

***This form is completed by DCF Personnel or the Contracted Client Services Provider for each service date.**

Region/Circuit/Institution:	**Program:**	**Subsection:**	
□ Customer □ Companion Name:	**Date:**	**Time:**	**Case No.:**
□ Deaf □ Hard-of-Hearing □ Deaf and Low Vision or Blind □ Hard-of-Hearing and Low Vision and Blind □ Deaf and Limited English Proficient □ Hard-of-Hearing and Limited English Proficient			
□ Scheduled Appointment □ Non-Scheduled Appointment □ No Show Date/Time:			
Name of Staff Completing Form:			

Section 1: Communication Assessment

□ Initial □ Reassessment □ Subsequent Appointment
Individual Communication Ability:
Nature, Length and Importance of Anticipated Communication Situation(s):
□ Communication Plan for Multiple or Long-Term Visits Completed □ Not Applicable
□ Aid-Essential Communication Situation □ Non-Aid Essential Communication Situation
Number of Person(s) Involved with Communication: **Name(s):**
Individual Health Status for Those Seeking Health Services:

Section 2: Auxiliary Aid/Service Requested and Provided

Type of Auxiliary Aid/Service Requested: **Date Requested: Time Requested:**
Nature of Auxiliary Aid/Service Provided: **Sign Language Interpreter: □ Certified Interpreter □ Qualified Staff □ Video Remote Interpretive Service □ Large Print** **□ Assistance Filling Out Forms □ Video Relay Services □ Florida Relay □ Written Material □ CART □ Other:**
Interpreter Service Status: □ Arrival Time: _____ □ Met Expectations of Client □ Met Expectations of Staff **□ No Show □ Cancellations**
Alternative Auxiliary Aid or Service Provided, including information on CD or Floppy Diskette, Audiotape, Braille, Large Print of Translated Materials:
Date and Time Provided:

Section 3: Additional Services Required

Was communication effective? □ Yes □ No If not, please explain why communication was not effective? **What action (s) was taken to ensure effective communication?**

Section 4: Referral Agency Notification

Name of Referral Agency:	
Date of Referral:	**Information Provided regarding Auxiliary Aid or Service Need(s):**

Section 5: Denial of Auxiliary Aid/Service by Department*

Reason Requested Auxiliary Aid or Service Not Provided:	
Denial Determination made by Regional Director/Circuit Administrator/Hospital Administrator or Designee or the Contracted Client Services Provider or their Designee:	
Denial Date:	**Denial Time:**

***Denials should only be made for non-aid essential communication. However, staff must still ensure that effective communication is achieved through whatever alternative means that are provided. Denial Determination can only be made by Regional Director/Circuit Administrator/Hospital Administrator or their Designee or the Contracted Client Services Provider or their Designee.**

Communication Plan for Ongoing Services

During the initial assessment, or the reassessment, if it is determined that **multiple or long term visits** will be needed, a Communication Plan shall be completed. Services shall continue to be provided to Customers or Companions, during the entire period of the Customer's hospitalization, residency, long term treatment, or subsequent visits. Discuss with the Customer or Companion their preferred mode of communication in each of the following on-going communication situations and incorporate into the case plan. The following list is not exhaustive and does not imply there are not other communication situations that may be encountered. **Refer to the instructions for further explanation**.

□ **Intake/Interview:**

□ **Medical:**

□ **Dental:**

□ **Mental Health:**

□ **Safety and Security:**

□ **Programs:**

□ **Off Campus trips:**

□ **Legal:**

□ **Food Service / Dietician**

Signature of person completing form:	Date:
Signature of Customer or Companion:	Date:

***This form shall be maintained in the customer's file.**

APPENDIX B:
CUSTOMER OR COMPANION REQUEST*
FOR FREE COMMUNICATION ASSISTANCE
OR
WAIVER OF FREE COMMUNICATION ASSISTANCE

The Florida Department of Children and Families and its Contracted Client Services Providers are required to provide **FREE interpreters or other communication assistance** for persons who are deaf or hard-of hearing. Please tell us about your communication needs.

My name is _____

☐ I want a free interpreter. I need an interpreter who signs in:

☐ American Sign Language (ASL) or an interpreter who speaks:

☐ Language: _____ Dialect: _____

☐ I want another type of communication assistance (Check all desired assistance):

Assistive Listening Devices: ____ Large Print Materials: _____ Note takers: _____

TTY or Video Relay: _____Assistance Filling out Forms: _____ Written Materials: _____ CART: _____

Other (Please tell us how we can help you): _____

_____

☐ I do not want a free interpreter or any other communication assistance. If I change my mind, I will tell you if I need assistance for my next visit. *(Customer or Companion waiver of rights does not prevent the Department from getting its own interpreter or from providing assistance to facilitate communication and to make sure rights are not violated)*

☐ I do not want a free interpreter because_____.

☐ I choose _____ to act as my own interpreter. He/she is over the age of 18. *It does not entitle my interpreter to act as my Authorized Representative. I also understand that the service agency may hire a qualified or certified interpreter to observe my own interpreter to ensure that communication is effective.*

Customer or Companion Signature:	Date:
Customer or Companion's Printed Name:	
Interpreter's Signature:	Interpreter's Printed or Typed Name:
Witness:	Date:
Witness Printed Name:	

***This form shall be attached to the Customer Companion Communication Assessment and Auxiliary Aid and Service Record form and shall be maintained in the Customer's file.**

APPENDIX C:
CUSTOMER OR COMPANION FEEDBACK FORM

The Department of Children and Families is committed to providing excellent customer service. We value your opinion and request that you complete this short survey to assist us in evaluating and improving our services. While you are not required to respond, we thank you in advance for completing this survey. You may remain anonymous, unless you wish to be contacted. When the form is completed, please mail it to: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 1, Room 110, Tallahassee, Florida 32399-0700. If you need assistance completing this form, please contact the Office of Civil Rights at (850) 487-1901 or TDD (850) 922-9220.

Program Area:_____ Location:_____

Department of Children and Families Survey

Your feedback is very important to us. We would greatly appreciate you taking a few minutes to complete this brief survey.

1. Were you offered any services to help you communicate? ☐Yes ☐No
2. Did you ask for any services to help you communicate? ☐Yes ☐No
3. If yes, what services to help you communicate did you receive? _____
4. Did you receive the services to help you communicate you asked for? ☐Yes ☐No
5. Did you understand completely? ☐Yes ☐No
6. Were you denied any services to help you communicate? ☐Yes ☐No
7. Were you satisfied with the services to help you communicate? ☐Yes ☐No
8. If not, why?_____
   _____
9. Did you know that these services to help you communicate were at no cost? ☐Yes ☐No
10. Did staff treat you with respect? ☐Yes ☐No

Can we contact you? Phone number or email:_____

THANK YOU!

Comments:

Please complete and return to: **Office of Civil Rights**
1317 Winewood Boulevard
Building 1, Room 110
Tallahassee, Florida 32399

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