CUSTOMER/COMPANION
COMMUNICATION ASSESSMENT AND
AUXILIARY AID/SERVICE RECORD

To be Completed by DCF Personnel or Contract Providers for Each Service Date.

<table>
<thead>
<tr>
<th>Region/Circuit/Institution:</th>
<th>Program:</th>
<th>Subsection:</th>
</tr>
</thead>
</table>

- [ ] Customer  [ ] Companion

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
<th>Time:</th>
<th>Case No.:</th>
</tr>
</thead>
</table>

- [ ] Deaf or Hard-of-Hearing  [ ] Visually Impaired  [ ] Limited English Proficient

- [ ] Scheduled Appointment  [ ] Non-Scheduled Appointment  Date/Time: 

Name of Staff Completing Form:

Section 1: Communication Assessment

- [ ] Initial  [ ] Reassessment

Individual Communication Ability:

Nature, Length and Importance of Anticipated Communication Situation(s):

- [ ] Communication Plan for Multiple or Long-Term Visits Completed

- [ ] 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:

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>Time Requested:</th>
</tr>
</thead>
</table>

Nature of Auxiliary Aid/Service Provided:

- [ ] Sign Language Interpreter:  [ ] Certified Interpreter  [ ] Qualified Staff  [ ] Video Relay Service  [ ] Other:

- [ ] Foreign Language Interpreter:  [ ] Language Line  [ ] Certified (Onsite)  [ ] Qualified (Onsite)  [ ] Qualified Staff

Interpreter Service Status:  [ ] Arrival Time:  [ ] Met Expectations

- [ ] No Show or Cancellation Without 24 Hr. Notice

Alternative Auxiliary Aid or Service Provided, Including Information on CD or Floppy Diskette, Audiotape, Braille. Large Print, of Translated Materials:

<table>
<thead>
<tr>
<th>Date and Time Provided:</th>
</tr>
</thead>
</table>

Section 3: Referral Agency Notification

Name of Referral Agency:

<table>
<thead>
<tr>
<th>Date of Referral:</th>
<th>Information Provided regarding Auxiliary Aid or Service Need(s):</th>
</tr>
</thead>
</table>

Section 4: 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:

<table>
<thead>
<tr>
<th>Denial Date:</th>
<th>Denial Time:</th>
</tr>
</thead>
</table>

*Denial Determination can only be made by Regional Director/Circuit Administrator/Hospital Administrator or designee.
Federal law requires the Florida Department of Children and Families and its contracted services providers/vendors to furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. Such auxiliary aids and services may include: qualified sign language or oral interpreters, note takers, computer-assisted real time transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, videotext displays, and TTYs.