# MONTANA DEPARTMENT OF CORRECTIONS

## INMATE ADA REQUEST ROUTING FORM

**Offender Name: _____ Offender Number: _____**
(Last) (First)

**Facility: _____ Unit: _____**

**Date Request Received by Inmate ADA Coordinator: _____**

**Type of Request: _____**

*Please follow steps in numbered order.*

1. **Inmate ADA Coordinator**

Is the request and/or concern an ADA issue?

- ☐ Yes *(develop proposed plan and proceed with step number 2)*
- ☐ No *(inform offender that his/her request is not an ADA issue)*

What disciplines does the request affect during the course of investigation?

- ☐ Medical
- ☐ Security
- ☐ Warden
- ☐ Legal
- ☐ Other: _____

Proposed Plan:

_____
_____
_____
_____
_____

Date submitted to Clinical Services Division Administrator: _____
Signature: _____ Date: _____
(Inmate ADA Coordinator)

2. **Clinical Services Division Administrator**

- ☐ Proceed with Proposed Plan
- ☐ Proceed with Alternative Plan
- ☐ Do Not Proceed
- ☐ Comments:

_____
_____
_____

Signature: _____ Date: _____
(Clinical Services Division Administrator)

**3. Inmate ADA Coordinator**

Revise proposed plan to align with Clinical Services Division Administrator comments
Revised Plan:

_____
_____
_____

Signature: _____ Date: _____

(Inmate ADA Coordinator)

**4. Review From Applicable Disciplines**

** If request needs to be presented to the Warden Management Team, the Clinical Services Division Administrator or designee will present the proposal.*

☐ Medical: _____
Initials: _____ Date: _____ Comments: _____

☐ Security: _____
Initials: _____ Date: _____ Comments: _____

☐ Warden: _____
Initials: _____ Date: _____ Comments: _____

☐ Legal: _____
Initials: _____ Date: _____ Comments: _____

☐ Other: _____
Initials: _____ Date: _____ Comments: _____

**5. Clinical Services Division Administrator**

☐ Approved
☐ Not Approved
☐ Comments:

_____
_____
_____

Signature: _____ Date: _____

(Clinical Services Division Administrator)

**6. Inmate ADA Coordinator**

☐ Proposal has been approved by Clinical Services Division Administrator and/or other disciplines (if applicable); proceed with resolution.
** In addition to this form, save the response letter, original request form and all other pertinent documentation for record keeping.*

☐ Proposal has not been approved by Clinical Services Division Administrator and/or other disciplines (if applicable); do not proceed.

Signature: _____ Date: _____

(Inmate ADA Coordinator)