



# OSCEOLA COUNTY TAX COLLECTOR'S OFFICE

## TITLE II ADA ACCOMMODATION

### REQUEST FORM

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Please return this completed form as far in advance as possible, but preferably at least 72 hours before the scheduled service, program or activity, to:

**Danielle Kreider, ADA Compliance Coordinator**

2501 E. Irlo Bronson Memorial Hwy.

Kissimmee, Florida 34742-2105

Phone: (407) 742-4035 or TTD 800-955-8771

Email: [ADATCO@osceola.org](mailto:ADATCO@osceola.org)

**1. Date request submitted:**

**2. Person needing accommodation**

Name: \_\_\_\_\_

**3. Contact information for person needing accommodation**

- Street or P.O. Box: \_\_\_\_\_
- City: \_\_\_\_\_
- State: \_\_\_\_\_
- Zip Code: \_\_\_\_\_
- Telephone Number (include area code): \_\_\_\_\_
- Email Address: \_\_\_\_\_

**4. Person making request (if other than the person needing the accommodation)**

- Name: \_\_\_\_\_
- Telephone Number (include area code): \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Relationship to person needing an accommodation: \_\_\_\_\_

**5. Accommodation information**

- Date accommodation needed: \_\_\_\_\_
- Time accommodation needed: \_\_\_\_\_
- Location accommodation needed: \_\_\_\_\_
- Duration for which the accommodation is requested: \_\_\_\_\_

**6. Accommodations requested**

- Nature of disability that necessitates accommodation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Accommodation requested (please check one of the following six options):

- Assistive listening device
- Communication access real-time translation/real-time transcription services
- Sign Language Interpreter (Please specify American Sign Language, oral interpreter, signed English, or other type of signing system used by persons with hearing loss.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Change to a facility that is accessible to a person using a mobility device (Please specify wheelchair, scooter, walker, or other mobility device that is used.): \_\_\_\_\_  
\_\_\_\_\_
- Provision of documents in an alternative format (Please specify Braille, large print, accessible electronic document, or other accessible format used by persons who are blind or have low vision.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Other accommodation (please specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THE FOLLOWING SECTION IS TO BE COMPLETED BY COUNTY PERSONNEL ONLY**

**8. Date request was received:**

**9. Additional oral or written information requested?**  Yes  No

If so, describe information: \_\_\_\_\_  
\_\_\_\_\_

**10. Describe the accommodation(s) granted by the County:** \_\_\_\_\_  
\_\_\_\_\_

**11. Indicate the duration the accommodation will be provided:** \_\_\_\_\_  
\_\_\_\_\_

**12. If an accommodation is denied, indicate reason(s) for denial:**

Based on the information provided, it appears the person does not have a disability as defined by the ADA

Requested accommodation does not directly correlate to functional limitations

Request relates to a service, program, or activity not provided by the County (transportation, legal representation, etc.)

Requested accommodation would result in an undue burden

Requested accommodation would result in a fundamental alteration

Other (please specify): \_\_\_\_\_

**13. Remarks:** \_\_\_\_\_  
\_\_\_\_\_

**14. County staff responding to request:** \_\_\_\_\_

**15. Date person notified of determination:**