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**Communication Aid/Accommodation Request Form**

The Florida Community Care (FCC) Notice of Nondiscrimination Policy provides free communication aids/services and reasonable accommodations upon request to any person when necessary to ensure equal opportunity and effective communication. If you are in need of communication aids/services or an accommodation, please complete this recommended form and email your request, as far in advance as possible, to [ADAcomplaint@fcchealthplan.com](mailto:ADAcomplaint@fcchealthplan.com), or submit to:

Nicolas Gross  
Civil Rights Compliance Coordinator Florida Community  
Care  
4601 NW 77th Avenue Miami, Florida 33166

**Requester Contact Information**

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

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred method of contact: \_\_\_\_\_

**Authorized Representative Making Request (if different than requester)**

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

Relationship to requester: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred method of contact\*: \_\_\_\_\_

**\*Please note:** if you are an Authorized Representative making a communication aid/service or accommodation

request on behalf of a requester and wish to be notified as to the status of the request, you must obtain a signed HIPAA authorization release form from the requester. This document can be found at: <https://fchealthplan.com/for-members/>

**Communication Aid/Service or Accommodation Request**

Location where communication aid or accommodation is needed: \_\_\_\_\_

Date communication aid or accommodation is needed: \_\_\_\_\_

Please describe the specific communication aid or accommodation requested:

Please provide any additional information that might be useful in reviewing your request:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Request No. \_\_\_\_\_

(For official use only)

**PRIVACY POLICY**

Submitted information is maintained and destroyed according to FCC's Notice of Privacy Practices. Copies of this notice can be viewed at:

<https://fcchealthplan.com/for-members/>

**FOR ADMINISTRATIVE USE ONLY: REQUEST NO. \_\_\_\_\_**

**ACTION TAKEN:**