



**State of Connecticut Department of Mental Health and Addiction Services  
Office of the Commissioner  
Deaf, Deafblind, Hard of Hearing (DHOH) Services Request Form**

The Connecticut Department of Mental Health and Addiction Services (DMHAS) provides Deaf, Deafblind Hard of Hearing (DHOH) services to persons with disabilities who receive services from or who are guests or visitors of DMHAS state-operated facilities, programs and activities.

DMHAS DHOH services include qualified sign language (visual gestural communication) interpreters for American Sign Language (ASL) Certified Deaf Interpreting (CDI), Home Sign, Tactile-Pro Tactile/Haptic Interpreting, Foreign Sign Language and Signed English as well as Communication Access Real Time (CART) and Video Relay Interpreting.

Information on DHOH services provided by a DMHAS state-operated facility or program is available from the DHOH contact person at each facility: [DMHAS DHOH Service Facility Contacts](#)

Information on DHOH services in the community can be found by contacting 2-1-1 Infoline.

This form is used by DMHAS divisions to request DHOH services administered by the DMHAS Office of the Commissioner.

**Instructions**

1. Requests for DHOH services are submitted when the organizer of a meeting or event receives a request for DHOH services as well as when the meeting or event:
  - Is open to the public without requiring prior registration.
  - Includes person or persons with disabilities who are known to need DHOH services.
2. Unless the request is urgent, requests are submitted at least ten (10) business days before the meeting or event to allow time for arrangements with a Connecticut Department of Administrative Services (DAS) contracted vendor of DHOH services.
  - If the event is an online meeting and the platform provides captioning, CART may not be required unless it is requested by a person with disabilities or the meeting is being recorded.
3. OOC DHOH Services Request Forms are submitted by Fax to 860-418-6690 or by ZIX encrypted email to [William.Pierce@ct.gov](mailto:William.Pierce@ct.gov)
4. Once a request is approved, the form is forwarded to a vendor who confirms the date, time and nature of the DHOH service. A copy of the confirmation is sent to the event's organizer who coordinates arrangements with the vendor as necessary.

For more information, contact William Pierce Voice 860-418-6933, TTY Relay 7-1-1  
[William.Pierce@ct.gov](mailto:William.Pierce@ct.gov)

DMHAS and other federally funded healthcare providers comply with federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability or sex (Affordable Care Act Section 1557).



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**Date Request Submitted** \_\_\_\_\_ **Date DHOH Service Needed** \_\_\_\_\_

Submit this request at least ten business days before DHOH services are needed.

**Type of DHOH service:** ASL  CART  CDI  VRI  Other (Specify) \_\_\_\_\_

Time From: \_\_\_\_\_ To: \_\_\_\_\_ Anticipated duration Hours \_\_\_\_\_ Minutes \_\_\_\_\_

Number of interpreters needed \_\_\_\_\_ (Two interpreters are required for events over 90 minutes)

**DMHAS Staff submitting request:** \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

**Contact Person** for event/activity: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Location/Venue** Online: Yes  No

Address/Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ Room/Floor Number: \_\_\_\_\_

**Format** General  Educational  Legal  Medical

**Setting** One on One  Meeting (up to 3 persons)  Group (more than 3 persons)

Public Event  Training  Testing  Other setting: \_\_\_\_\_

**Frequency** (Check one) Single Event  Repeated Event

Describe how often (IE: "Every week on a Monday"): \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_ *Submit separate request forms for each occurrence.*

**Other requirements** (IE: Spanish or other spoken languages, Directions, Parking, Seating arrangements, Microphones): \_\_\_\_\_

*Submit an agenda with this request to help DHOH service vendor prepare for your event.*

**Number of individuals needing service:** \_\_\_\_\_

**Name of person needing service (optional):** \_\_\_\_\_

Person's gender preference of interpreter(s) *leave blank if no preference:* Male  Female

**Preferred method of communication and other preferences:** \_\_\_\_\_

**Send completed request forms to DMHAS OOC DHOH Services**

- DHOH Service requests from DMHAS funded providers are submitted by their DMHAS contract manager
- Email completed forms using ZIX encryption to: [William.Pierce@ct.gov](mailto:William.Pierce@ct.gov) or fax to 860-418-6690.
- For more information contact William Pierce Voice 860-418-6933, TTY Relay 7-1-1 [William.Pierce@ct.gov](mailto:William.Pierce@ct.gov)

**DMHAS OFFICE OF THE COMMISSIONER DHOH SERVICES APPROVAL**

**Approved by:** \_\_\_\_\_

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

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