EXAM ACCOMMODATIONS REQUEST FORM

In an effort to provide equivalent access for all applicants taking the examination for Medi-Cal Peer Support Specialist certification, the testing interface has been designed to be accessible under the Web Content Accessibility Guidelines 2.1 AA ("WCAG 2.1AA"). The Web Content Accessibility Guidelines make Web content more accessible to people with disabilities. If the nature or extent of your disability is such that, despite WCAG 2.1 AA accessibility, you believe you will need special accommodations in order to complete the exam, you may request reasonable accommodations in accordance with the CalMHSA Reasonable Accommodations for Medi-Cal Peer Support Specialist Examination policy. Full compliance with the requirements is necessary in order to process reasonable accommodations requests.

Please have a qualified licensed medical provider complete this form to request testing accommodations. The information provided will be held in strict confidence. Please note that some accommodations may require the candidate to contact the test center directly to ensure accommodation is in place. **This form is due to CalMHSA at least 30-days before the desired testing date, in accordance with policy.**

Part 1: Candidate Information.

Full Legal Name: _____

Date of Birth: _____

Email Address: _____

Telephone Number: _____

I am requesting testing accommodations. I understand that my request must be supported by recent information as noted on this document from a qualified medical professional pursuant to CalMHSA's Exam Accommodations Policy. I further understand that any cost related to collecting documentation is my personal responsibility; however, I will not bear any cost for approved accommodations provided to me at a CalMHSA test site.

_____ _____

Candidate Signature (electronic or manual signature accepted) **Date:**

Part 2: Documentation of Eligibility for Reasonable Accommodations.
Please have this section completed by a qualified licensed medical provider.

I have evaluated _____ on _____
(Patient's Name) (Date)

In my capacity as a _____
(Professional Title)

The examination candidate listed above discussed with me the nature of the examination to be administered. I understand the exam is a 120 item, multiple-choice exam administered on a computer in an on-line format. Candidates have two and half (2.5) hours to complete the exam, with a ten (10) minute break approximately in the middle.

It is my opinion that, because of the candidate's disability, the candidate should receive the testing accommodations as described below.

Check all that Apply for Online-Proctored Exams:

- ☐ Use of screen reader application
- ☐ A beverage is permitted during testing
- ☐ A snack is allowed during testing

Extended testing time (please select **one** of following three options):

- ☐ 30 minutes of additional time, **or**
- ☐ 50% of original time, **or**
- ☐ 100% of original time

- ☐ Glucose meter and testing supplies during testing
- ☐ Liquid medicine during testing
- ☐ A service animal
- ☐ A stool or footrest
- ☐ Waiver of Automation Tools
- ☐ Other (please specify):

_____

Medical Provider Name: _____

License Number: _____

Medical Provider Signature _____**Date**_____
(electronic or wet signature)

Check All that Apply for In-Person Testing Locations:

- ☐ Use of screen reader application
- ☐ A beverage is permitted during testing
- ☐ A snack is allowed during testing
- ☐ Ear plugs
- ☐ English or Spanish Dictionary
- ☐ Frequent or extended breaks

Extended testing time (please select **one** of following three options):

- ☐ 30 minutes of additional time, **or**
- ☐ 50% of original time, **or**
- ☐ 100% of original time

A separate room (please select one of the following options):

- ☐ Stand and move as needed
- ☐ Read aloud
- ☐ A Reader and/or Recorder is needed
- ☐ An Interpreter is needed
- ☐ A snack
- ☐ 50% of original time, **or**
- ☐ Glucose meter and testing supplies during testing
- ☐ Liquid medicine during testing
- ☐ A service animal
- ☐ Access to medical devices during testing
- ☐ Nursing Mother accommodation
- ☐ Adjustable armless chair and/or workstation
- ☐ Adjustable contrast and/or font size
- ☐ An Interpreter (for communication w/ staff only)
- ☐ Sunglasses during testing
- ☐ Zoom text (screen mag only)
- ☐ Access to locker
- ☐ Other (please specify):

_____

Medical Provider Name: _____

License Number: _____

Medical Provider Signature _____**Date**_____
(electronic or wet signature)

Part 3: Submission of Form.

1. Request must be made using this form. Additional supporting documents may be submitted along with this form, if desired.

2. Requests will be processed only for individuals with an approved application for examination.

3. Request form must be submitted to CalMHSA via email or by mail at least 30-days before the desired testing date. The 30-day timeframe starts from the date of the approval of the application for examination.
   - Email address: PeerCertification@calmhsa.org
   - Physical address: 1610 Arden Way, Suite 175, Sacramento, CA 95815

4. CalMHSA will review all complete reasonable accommodations requests and will notify the applicant of the status of the request for exam accommodations within 30 days from the date the request was made. Applicants will be notified via email on file on the application for examination.

If you have questions about this form, please contact us at PeerCertification@calmhsa.org or call us at (279) 234-0699 during normal business hours, 8 AM – 5 PM, Monday – Friday, excluding holidays.

In the event the applicant disagrees with the decision, the applicant may file an appeal with the reason for disagreement. Please follow the appeals process guidelines located in the "Guidelines, Standards, and Procedures Manual."