ATTESTATION OF THE REQUIREMENTS OF:

* Section 504 of the Rehabilitation Act
* Fact Sheet Title II of the ADA
* Auxiliary Aids Policy and Plan for
Participants or Companions or Potential Participants or Companions with Disabilities
* Roles and Responsibilities of the Single-Point-Of-Contact and
the DCF ADA/504 Coordinator

#### ACKNOWLEDGEMENT FORM

CDS Family & Behavioral Health Services, Inc.

I hereby acknowledge that I am familiar with the requirements of Section 504 of the Rehabilitation Act, Fact Sheet Title II of the ADA, and the Auxiliary Aids Policy and Plan for Participants or Companions or Potential Participants or Companions with Disabilities. I received the names, contact information, and Roles & Responsibilities for the Single-Point-of-Contact and the DCF ADA/504 Coordinator. I understand that I will contact the Single-Point-of-Contact, within my office, regarding assistance with the delivery of services to deaf or hard-of-hearing customers. I understand that it is my responsibility to review these policies in detail and request any clarification needed from my supervisor or human resources.

I also understand that this signed acknowledgement of receipt will become a permanent part of my personnel file.

 Printed name:

 Signature:

 Date: