Inmate Disability Evaluation Form

Inmates Name:		DOB:	PFN:	Date:

Medical Staff _____ **Time:** _____
Name

Deputy Notified _____ **Time:** _____

Section A: Reason for Initiation of Form (Check all that apply).

☐ Inmate Self-Identified ☐ Intake Generated ☐ Staff Observation
☐ Mental Health Staff ☐ Medical Staff ☐ Third Party Request
☐ Classification File ☐ Medical File

Section B: Categories or Disability

☐ Vision Impaired ☐ Mobility Impaired ☐ Speech Impaired
☐ Other ☐ Hearing Impaired

Section C: Disabilities Affecting Placement

☐ Wheelchair User ☐ Mobility Impaired ☐ Hearing Impaired
☐ Non-Ambulatory ☐ Mentally Impaired ☐ Vision Impaired
☐ Other

Section D: Activities of Daily Living
List assistance needed with daily living activities(walking, seeing, caring for oneself, etc)

Medical Staff's Name: Signature: Date:

Section E: Classification Action

Class Review: ☐ Yes ☐ No
Accessible Housing Available ☐ Yes ☐ No

Classification Officer's Signature: _____ Date: _____
Classification Sergeant's Signature: _____ Date: _____
ADA Coordinator's Signature: Date:

Section F: Staff Comments/Observations

Distribution: White -- Medical Yellow -- Classification Pink -- ADA Coordinator