Request for Reasonable Accommodation

Tenant ID:

The CoAc (HA) provides "Reasonable Accommodation" to applicants and/or participants with disabilities. A "Reasonable Accommodation" is a change, exception, or adjustment to a rule, policy, practice or service that may be necessary for a person with a disability to have equal access to the HA's programs and services. The request for the accommodation must be reasonable and not an administrative or financial burden or alter the fundamental nature of the Voucher program.

If you, or anybody, in your household, has a verifiable disability and you need a reasonable accommodation, please complete this form to request the Reasonable Accommodation. All requests are reviewed on a case-by-case basis and the HA considers all information provided. The accommodation must be for a person with a disability. To be considered disabled, a person must have a disability as described below:

(1) a physical or mental problem that substantially limits one or more life activities (or)
(2) having a record of such a problem (or)
(3) being regarded as having such a problem

1. **The following member of my household has a verifiable disability as defined above:**

   Name: _____ Relationship to you: _____

2. **As a result of this disability, I am requesting the following accommodation:**

   ☐ A change in my apartment or other part of the housing development (please specify below):

   ☐ A change in the following rule, policy, or procedure (Note that a change in how to meet the terms of the lease may be requested but the terms of the lease must be met.) (please specify below):

   ☐ Other (For example, a change in the way the Housing Authority communicates with you). (please specify below):

   _____

   _____

3. **The request for reasonable accommodation is necessary so that I (or my family member) can *(please specify)*:**

   _____

4. **I authorize the HA to verify that I (or my family member) have a disability and have the need for the specific accommodation I have requested. In order to verify this information, the HA may contact the following licensed professional:**

   Name: _____

   Title of professional or expert: _____

   Agency, Facility or Institution (if any): _____

   Address: _____

   Telephone: _____

I understand that the information obtained by the Housing Authority will be kept completely confidential and used solely to make a determination on my accommodation request.

X _____ Date _____

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ihcda
Indiana Housing & Community Development Authority

DISABILITY/REASONABLE ACCOMMODATION VERIFICATION

To: _____ From: CoAc
_____ CoAction
_____ Crown Point, IN 46307
Fax: _____ Fax: 219-794-1860

SUBJECT: Verification of Information Supplied by an Applicant/Participant

Name: _____
Date of Birth: _____
Name of Person Requiring a Reasonable Accommodation _____

I hereby authorize release of my medical information to the above names source.

_____ _____
Signature of Applicant/Tenant Date

The above named person has applied for housing assistance under a program of the US Department of Housing and Urban Development (HUD). HUD requires the Public Housing Authority to verify all information that is used in determining this person's eligibility or level of benefits.

If you have first hand knowledge that one or more of the following conditions exist, please complete this questionnaire and return directly to the agency/person listed above.

We ask your cooperation in providing the following information and returning it to the person listed on the top of this page. Your prompt return of this information will help assure timely processing of the application for assistance. The applicant/tenant has consented to a release of medical information as shown above.

This verification is required for the applicant/tenant to receive allowances and or exemptions available only to households whose Head, Spouse, or sole member is disabled and/or to determine if accommodations requested by the a disabled applicant/participant will eliminate barriers to housing that prevent full participation in the Housing Choice Voucher Program.

Does the above named person meet one of the following definitions of disability? Please indicate all that apply by checking yes or no.

Yes ____ No ____ 1. A person having physical or mental impairment that:

- is expected to be of long-continued indefinite duration
- substantially impeded the person ability to live independently; and
- is such that the person's ability to live independently could be improved by more suitable housing conditions.

Yes ____ No ____ 2. A person has a developmental disability as defined by the Developmental Disabilities Assistance and Bill of Rights Act. (42US 6002(7)) generally provided as follows:

- is attributable to a mental and/or physical impairment or combination of mental and physical impairments;
- is likely to continue indefinitely;
- results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care; receptive and responsible language, leaning mobility; self-direction; capacity for independent living; and economic self-sufficiency; and

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- reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong, or extended duration and are individually panned and coordinated.

Yes ____ No ____ 3. A person who has a chronic mental illness, i.e., if he/she has a severe and persistent mental or emotional impairment that seriously limits his/her ability to live independently (e.g. limiting functional capacities relative to primary aspects of daily living, such as personal relations, living arrangements, work, recreation, etc.) and whose impairment could be improved by more suitable housing conditions.

Yes ____No ____ 4. A person who is institutionalized, or at risk of institutionalization, is living in or at risk of being placed in a nursing facility, long term rehabilitation center or hospital.

Risk of Institutionalization is defined as households with a disability whose functioning is so impaired as to interfere with their capacity to remain in the community without supportive treatment. The disability is severe and persistent and may limit their capacities for engagement in primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The disability may limit their ability to seek or receive local, state, or federal assistance such as housing, medical, and dental care, rehabilitation services, income assistance, and food stamps, or protective services.

Yes ____ No ____ 5. Does this household require the assistance of a live in aide to accomplish activities of daily living, including personal care, which the applicant/tenant cannot perform because of his/her disability?

Accommodation Requested By Participant/Applicant:

_____
_____
_____

Please provide specifics on how the accommodation requested above will benefit the applicant/participant:

_____
_____
_____
_____

Under penalty of perjury, I/we certify that the information presented in this verification is true and accurate to the best of my/our knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of the Section 8 Housing Choice Voucher program.

_____ _____
Signature of Person Completing this form Date

_____ _____
Please Print Name and Title Telephone

EQUAL HOUSING OPPORTUNITY

We encourage and support the nation's affirmative housing program in which there are no barriers to obtaining housing because of race, color, religion, sex, national origin, handicap or familial status

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