# REQUEST FOR REASONABLE ACCOMMODATION

## Instructions

1. Complete the **Client Information** section in full.
2. **Must** answer questions 1 ‐ 4 *(****Note:*** *a family member* ***must*** *meet the definition of disability in order to make a request)*
3. Health Care Provider Statement **must** accompany this request.

***\*\*Medical details of diagnosis and treatment are not required***

## CLIENT INFORMATION

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Head of Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last 4 digits of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_**



**Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act, and the Federal Fair Housing Act, as amended, defines individuals with disabilities as any person who:** Has a physical or mental impairment that limits **"Major life activities"** ‐ functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working; Has a **"record of such an impairment"** ‐ a history of, a mental or physical impairment that substantially limits one or more major life activities;

1. **Are you, or any family member disabled as defined above?**

If No ‐ **Stop Here.** You may not request a reasonable accommodation. If Yes ‐ **Complete the remaining questions.**

## Name and date of birth of family member that meets definition of disabled:

Relationship to Head of Household:

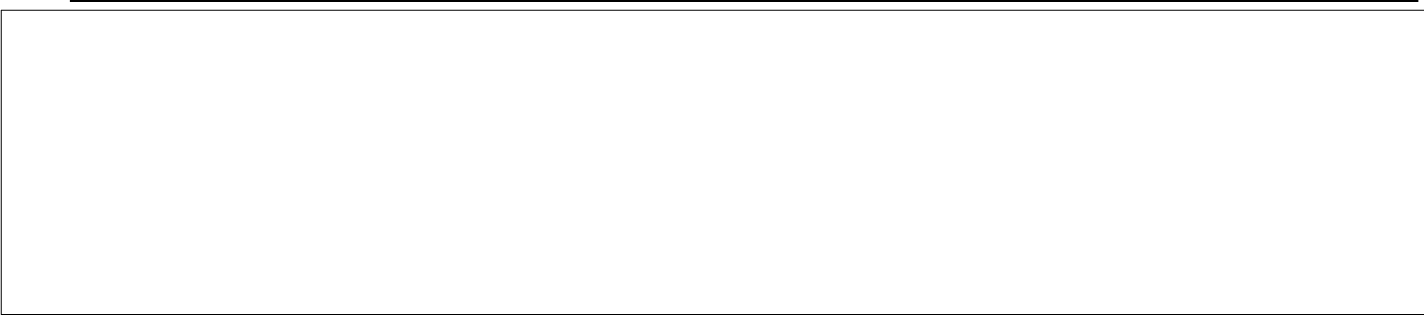
1. **Accommodation Requested** (Check the appropriate accommodation from the options below)**:**

***Requested accommodation or modification must be necessary for the disabled person's full enjoyment of PHA programs or facilities, and the necessity must be substantially related to the individual's disability.***

Structural Modification ADA Unit Live‐in Aide Shared Housing/Rent from Relative Increase Voucher Size Medical Expenses Service/Companion Animal Voucher Extension (Prior Extensions Approved?) Yes No

Other:

## What is the claimed disability and what is the connection between the accommodation requested above and the person's disability?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



I hereby authorize the above‐named Health Care Provider to complete the Health Care Provider Statement and disclose to the Northwest Georgia Housing Authority (“NWGHA”) and its authorized representatives the following information related to my health care: medical and mental health information concerning whether I have a disability and whether the accommodation I have requested is medically necessary to accommodate my disability by making housing and housing services accessible for me.

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken based on the original authorization.

Client/Tenant Signature Date

# HEALTH CARE PROVIDER STATEMENT

The below‐named person has indicated that they have a disability that requires an accommodation in order to enable them equal access to, and enjoyment of, their housing. **Note that such changes must be necessary as a result of the person's disability or handicap as opposed to a change that merely benefits the individual.**

Specify the accommodation that you recommend, indicate whether you believe the person with a disability meets the definition provided, and whether the accommodation is substantially related to the individual's disability.

This form must be completed by a qualified professional whose function is to provide services to the person with a disability. It is important to be as clear as possible about what is being requested in order to help us provide the most appropriate response. **What is the claimed disability? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**CLIENT INFORMATION**

**Family Member with Disability:**

**Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act, and Federal Fair Housing Act defines individuals with disabilities as any person who:** Has a physical or mental impairment which substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having an impairment.

## VERIFICATION OF DISABILITY



**ACCOMMODATION**

Disability is: PERMANENT TEMPORARY If **temporary**, how long do you anticipate disability?

**2. Need for accommodation is:** PERMANENT TEMPORARY If **temporary**, how long do you anticipate need?

NO

YES

**1. In my opinion, the above‐named family member has a disability as defined above:**

**In my professional opinion and assessment of disabled person's needs, I certify the following:**

(Select the requested accommodation from the options below)

1. Description of the accommodation being requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. In your medical opinion do you believe the individual has a disability that substantially limits a major life activity?  Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How is the above reasonable accommodation/modification necessary for the individual to have equal use of their home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long has the individual been under your professional care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## HEALTH CARE PROVIDER CERTIFICATION

The information provided herein is true and correct to the best of my knowledge.

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Health Care Provider Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name and Title (printed) Phone Number