REASONABLE ACCOMMODATION REQUEST FORM

Head of Household Name: _____

Address: _____ City, State & Zip: _____ Phone: _____

SECTION 1: CLIENT'S REQUEST FOR REASONABLE ACCOMMODATION AUTHORIZING RELEASE OF INFORMATION

This request is for (family member): _____ Date of Birth: _____

I am a:

☐ Voucher Holder or applicant (HCV, Section 8, VASH) Last 4 SSN: _____

☐ Resident of a Homes for Good Managed Community Property Name: _____

A reasonable accommodation, modification or exception to a policy is being requested for the following reason(s):

Please describe the accommodation you are requesting and how it will assist you by removing barriers to housing and allow you to fully access and utilize Homes for Good's program(s).

_____

_____

_____

_____

_____

Section 504 allows Homes for Good to obtain confirmation that the reasonable accommodation request is consistent with the client's disability as defined below. To determine whether your request for accommodation is reasonable, we require an impartial, knowledgeable and qualified professional to complete Section 3 of this form. Therefore, your consent authorizing the release of this information is necessary. This information will be held in confidence for use in evaluating the reasonable accommodation request.

By signing below, you authorize the qualified professional to release specific information requested in Section 3 of this form to Homes for Good Housing Agency to verify the request for reasonable accommodation *(this form should be signed by the disabled member of the household requesting accommodation. Note: if the disabled member is a minor, the parent/guardian must sign on their behalf).*

X_____ _____

Signature Authorizing Release of Information *Date*

If you have any questions, please call Greg Frazer, ADA Coordinator at (541) 682-3404.

SECTION 2: HUD DEFINITION OF DISABILITY

Section 504 of the Rehabilitation Act of 1973 & Fair Housing Amendments define a "disability" as:

- A physical or mental impairment that substantially limits one or more of the person's major life activities*
- A record of having such an impairment, or
- Being regarded as having such impairment

*Physical & mental impairments including physiological disorders or conditions, and mental or psychological disorders.

SECTION 3: HEALTHCARE/QUALIFIED PROFESSIONAL'S CERTIFICATION OF NEED FOR ACCOMMODATION

Dear Healthcare or qualified professional,

We ask that you carefully review this patient's/client's request and verify, using your professional opinion, the existence of an impairment that substantiates the reasonable accommodation request. Requests will be considered on a case-by-case basis, as people with the same disability may not need or desire the same type of accommodation. To help us make an informed decision, please write legibly.

Please note that such accommodations must be necessary because of the person's disability as opposed to a change that merely benefits the individual. We ask that you give careful, thought to this matter as this affects the total number of families we can assist.

FOR HEALTHCARE/QUALFIFEID PROFESSIONAL TO COMPLETE: *This is not a request for medical records or detailed information about the disability*. Please limit your remarks to describing the functional limitation(s) and to confirming that the accommodation that is requested above is relevant to the client's need. Thank you.

Patient Name: _____ Date of Birth: _____

1. Does the individual have a disability, as defined on the previous page? ☐ Yes ☐ No

   - **If you answered "Yes," please answer questions 2-5. If you answered no, please sign and return this form.**

2. Please give us an idea of how long the need will last.

   ☐ Temporary (12 months or less) ☐ Permanent (lifelong) ☐ Other _____

3. The following are major life activities as defined in Section 504 of the Rehabilitation Act. Please check all the activities that are affected by the patient's diagnosed impairment and are connected to the accommodation request.

   ☐ Self-Care ☐ Manual Tasks ☐ Walking ☐ Vision ☐ Hearing

   ☐ Speaking ☐ Breathing ☐ Learning ☐ Working ☐ Other _____

4. Please describe how the requested accommodation will assist your patient/client with the limitation(s) posed by the disability, removing barriers to housing and allowing them to fully access and utilize the program *(please print):*

_____

_____

_____

5. If the accommodation cannot be provided, please list all alternatives that would serve to make the housing program accessible *(please print):*

_____

_____

_____

I certify that it is my professional opinion that the above-named individual has a qualified disability that has a direct and verifiable need for accommodation in order to fully utilize the housing program. I understand that I could be called to testify regarding the validity of the information provided in this form. I further certify that my professional opinion is in compliance with all applicable laws, regulations, standard industry practices and licensing guidelines.

Professional's Name: _____ Professional's License No.: _____

Address: _____

Phone No.: _____ Fax No.: _____

Professional's Signature: _____ Date: _____