

## Reasonable Accommodation Request

**Program Information:**

- If you or anyone in your family is a person with disabilities and you require a specific accommodation to fully utilize our programs and services, this form may be used to make a request.
- A reasonable accommodation request may be submitted at any time.
- All reasonable accommodation requests are reviewed on a case-by-case basis.
- We will review your request and send a written response within 15 business days of receiving the request or the most recent discussion about the request.

**Instructions:**

- **Page 1 must be completed by the applicant/participant or someone on their behalf.**
- Please answer all questions on the form.
- If you need assistance or have any questions, please call the number above.

### Applicant/Participant Request

**Head of Household Name:**

**Current Address:**

**City:**

**State:**

**Zip Code:**

**Phone:**

**Name of person needing the accommodation:**

**Please describe the reasonable accommodation requested:**

**Reason for requesting the accommodation, why it is needed:**

**If applicable, Case Manager Name:**

**Phone:**

### Applicant/Participant Certification

*I give Home Forward permission to talk with the case manager identified above and/or the person verifying the disability and this reasonable accommodation request.*

**Warning:** Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction, punishable by fine not to exceed \$10,000 and/or imprisonment of not more than 5 years.

*I certify the information in this Reasonable Accommodation Request is true and accurate.*

**Head of Household Signature:**

**Date:**

### Home Forward Use Only

**RASC Name:**

**Tcode:**

## Verification of Disability for Reasonable Accommodation Request

### Instructions:

- **Page 2 must be completed by an individual identified by the family who is competent to make the determination:** a doctor or other medical professional, a peer support group, a non-medical service agency, or a reliable third party who is in a position to know about the individual's disability may provide verification of a disability for purposes of this reasonable accommodation request.
- Please answer all questions below

### Verification of Need for Reasonable Accommodation

*Home Forward is required by law to provide reasonable accommodations in rules, policies, practices, or services when such accommodations may be necessary to afford a person with a disability equal opportunity to use and enjoy our housing programs and services. Home Forward does not provide reasonable accommodations when the request is a matter of convenience or preference only.*

*Applicable federal and state law defines "disability," with respect to the individual, as:*

- 1. a physical or mental impairment which substantially limits one or more of such person's major life activities; Major life activities are defined as functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.*
- 2. a record of having such an impairment; or*
- 3. being regarded as having such an impairment; but such term does not include current illegal drug users, people whose alcohol use interferes with the rights of others, or people who objectively pose a direct threat or substantial risk of harm to others that cannot be controlled with a reasonable accommodation under the HCV program.*

**Name of person needing the accommodation (please print):**

**Please describe what kind of accommodation is needed due to the disability:**

**Please describe why the accommodation is necessary to assure equal housing access, i.e., how it helps the person participate in Home Forward housing programs and/or use their assisted unit:**

**Please verify the above requested accommodation is:**

1. related to the applicant's/participant's disability as defined above  **Yes**  **No**
2. necessary to provide the applicant/participant with an equal opportunity to participate in and use our housing program(s), their unit, and/or common areas.  **Yes**  **No**

### Certification

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*I certify the information in this Verification of Disability for Reasonable Accommodation Request is true and accurate.*

Signature:

Date:

Name Printed:

Phone:

Title/Qualification:

Fax:

Agency/Office Address: