HOUSING AUTHORITY OF SNOHOMISH COUNTY
12711 - 4th Avenue West - Everett, Washington 98204
(425) 290-8499 or (425) 743-4505
FAX (425) 290-5618

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 unless disability and the need for accommodation are obvious.
   ****Medical details of diagnosis and treatment are not required***

HASCO CLIENT INFORMATION

Today's Date: _____ **Health Care Provider**: _____

Head of Household: _____ **Office/Clinic**: _____

Client's Housing Program: _____ **Phone**: _____ **Fax**: _____

Last 4 digits of SSN: _____ **Street Address**: _____

Birth Date: _____ **City**: _____ **Zip Code**: _____

Section 504 of the Rehabilitation Act of 1973, 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 oneself, 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;

"Is regarded as having an impairment" - is treated by a medical/health care professional for such impairment.

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.**

2. **Name of family member that meets definition of disabled:** _____ **Date of Birth**: _____
   Relationship to Head of Household: _____
   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 HASCO programs or facilities, and the necessity must be substantially related to the individual's disability.
   - **Note – accommodations such as structural modifications, ADA units, and Service animals apply only to properties managed by HASCO. Voucher holders should ask their landlords if they may need such accommodations.**

   ☐ Structural Modification ☐ ADA Unit ☐ Service/Companion Animal ☐ Shared Housing ☐ Rent from Relative
   ☐ Separate Bedroom ☐ Medical Expenses ☐ Live-in Aide ☐ Voucher Extension (Prior Extensions Approved?) ☐ Yes ☐ No
   ☐ Other: _____

3. **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 Housing Authority 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 also authorize the health care provider to discuss with the Housing Authority and its representatives alternative forms of accommodation which might be used to achieve the needed accessibility result. The health care provider is authorized to disclose any and all health care information which would otherwise be held as confidential in order to assist the Housing Authority in determining whether the accommodation I have requested is necessary and/or whether an alternative accommodation would achieve the same result.

This authorization is valid for twelve (12) months after the date of my signed release. 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 Signature Date

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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 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. **Note: Medical details of diagnosis and treatment are not required.**

HASCO CLIENT INFORMATION

Family Member with Disability:

Section 504 of the Rehabilitation Act of 1973 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

1. In my opinion, the above-named family member has a disability as defined above: ☐ YES ☐ NO

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?

ACCOMMODATION

In my professional opinion and assessment of disabled person's needs, I certify the following:
(Select the requested accommodation from the options below)

☐ **Structural Modification to a Non-ADA Unit** *****Structural modifications may be limited based on the structure/size of the unit*****
e.g., ramp, grab bars, ground floor unit, raised toilet, etc.

Modification request:

Relationship between limitations and request:

If Mobility Limitation: Max # of stairs Walking distance limitation Assistive Device

☐ **ADA Unit** *****ADA units are based on availability*****
Definition: A one-level until which is fully accessible to a person in a wheelchair or to a person with substantial mobility impairment. Features of the unit include wider doors and hallways, lower cabinets/sinks, and accessible closets.

Why is ADA unit necessary, due to disability:

☐ **Live-in Aide (Includes separate bedroom)**

Does disability require a live-in aide to perform daily activities (e.g., housekeeping, hygiene, shopping, etc.)? ☐ YES ☐ NO

Why is live-in aide necessary, due to disability:

Definition of Live-In Aide (24 CFR Section 5.403): Person who resides with one or more elderly persons, or near-elderly persons, or persons with disabilities, and who: 1) Is determined to be essential to the care and well-being of the persons; 2) Is not obligated for the support of the persons; and 3) Would not be living in the unit except to provide the necessary supportive services.

*****Occasional, intermittent, multiple, or rotating caregivers do not meet the definition of a live-in aide*** *since 24 CFR Section 982.402(7) implies live-in aides must reside with the family permanently for the family unit size to be adjusted in accordance with the subsidy standards established by the PHA. Therefore, regardless of whether these caregivers spend the night, an* ***additional bedroom should not be approved. *****

☐ **Policy Modification/Other** **Mobility Limitation:** Assistive Device Walking distance limitation

Requested change:

Disability-related need:

☐ **Special Housing** ***If the owner of the unit is a relative and resides in the unit, then request should be for Rent from Relative****

Shared Housing is defined as a single housing unit occupied by an assisted family and another resident(s); and consists of common space for use by all occupants and separate private space for the assisted family.

Type of special housing: ☐ Shared Housing ☐ Rent from Relative

Does the disabled person's current condition necessitate special housing? YES ☐ NO ☐

If **YES**, disability-related need for special housing:

☐ **Separate Bedroom** **** Voucher size does not determine who within a household will share a bedroom/sleeping room. ****

HASCO will subsidize one bedroom for the head of household and spouse/cohead, and one bedroom for each two additional persons within the household, regardless of age, gender, or relationship.

Does patient's current condition necessitate a separate bedroom? ☐ YES ☐ NO

If **YES**, disability-related need for separate bedroom:

Is extra space necessary to accommodate medical equipment (e.g., Hospital bed, dialysis machine, etc.)? ☐ YES ☐ NO

	Equipment	Dimensions (*H x W x D*)
1.		
2.		
3.		

Would a large closet or other storage space be an acceptable alternative? ☐ YES ☐ NO

If **NO**, why not:

☐ **Medical Expenses** *(Include all expenses: OTC medications, medical supplies/equipment, etc. that apply)*

Over the counter medications (list below)

1. 3.
2. 4.

Medical supplies/equipment (list below)

1.
2.

Other (explain in detail):

Relationship between medical expenses and disability:

☐ **Service/Companion Animal**

Type of Animal: ☐ Service ☐ Companion

Animal name & species:

Disability-related need for each Service/Companion Animal:

Service Animal *as defined by ADA: Any dog or miniature horse (where reasonable) that is individually trained to do work or performtask(s) for the benefit of a person with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The work or tasks performed must be directly related to the disability.*

Companion Animal*: Provides emotional support to person with a disability, who has a disability-related need for such support.*

☐ **Voucher Extension**

Disability-related need:

HEALTH CARE PROVIDER CERTIFICATION

The information provided herein is true and correct to the best of my knowledge. I acknowledge that I may be contracted for further clarification of this certification and on an annual basis to re-verify this information.

Health Care Provider Signature

Date

Health Care Provider's Name and Title (printed)

Phone Number

Equal Housing Opportunity