

Request for Reasonable Accommodation Information and Forms

A reasonable accommodation is some exception, modification or change made to rules, policies, practices, or services that will assist a person with a disability in taking advantage of the full benefits of a property or dwelling. A housing provider must grant a request for reasonable accommodation if the accommodation may be necessary for the individual to have an equal opportunity as persons without a disability to enjoy or use a dwelling.

Reasonable accommodations may include but are not limited to:

- ✓ A change in the rules or policies that would make it easier for you to live in your apartment, house or dwelling.
- ✓ Permitting a service animal for a household in a community that does not allow pets or not charging a deposit for a service animal even though a deposit is traditionally charged for pets.
- ✓ A change in the way the management communicates or provides information to the tenant.

If you are requesting a **reasonable accommodation**, please complete the following attached forms:

- Request for Reasonable Accommodation
- Verification of Status as a Person with a Disability
- Approval or Denial of Request for Reasonable Accommodation

TDD phone numbers: 1 (800) 854-7784 (voice to voice), 1 (800) 735-2929 (English-TTY/type to voice), 1(800) 855-3000 (Spanish-TTY/type to voice).

http://www.ddtp.org/california_relay_service/how_to_make_a_relay_call/

Request for Reasonable Accommodation
(to be completed by tenant/applicant)

If you or a member of your household has a disability and needs a reasonable accommodation in order to have equal use and access to the complex, house or community, please complete and submit this form to your housing provider.

Please keep copies of your completed documents for your personal records.

Date: _____

1. Name of tenant or applicant: _____

Telephone #: _____

Address: _____

Name of person with disability (if different than the previous name)

Telephone #: _____

Address: _____

2. I am requesting the following change(s) in a rule, policy, practice, or service so that my household members and I can live here as easily as others and equally enjoy and participate in housing:

3. I need this reasonable accommodation because: _____

4. If you know of a company, organization or individual that might be able to help or advise on the changes, please provide the following information.

Name: _____

Address: _____

Telephone #: _____

Please notify me within **ten days** by completing the attached **Approval or Denial of Request for Reasonable Accommodation** form.

Signature

Date

Name of tenant/applicant

Verification of Status as a Person with a Disability
(to be completed by medical or social service professional or other third party)

To: _____

Re: _____
(Name of tenant or applicant)

Address: _____

The tenant or applicant for tenancy listed above has sought the reasonable accommodation described in the attached request. State and federal laws require housing providers to make reasonable accommodations in rules, policies, practices or services when the changes are not unduly burdensome and may be necessary to afford a person with a disability with the equal opportunity to use and enjoy a dwelling.

The Fair Housing Amendments Act and the Americans with Disabilities Act define disability as:

- ✓ A physical or mental impairment that substantially limits a major life activity; or
- ✓ A record of such an impairment; or
- ✓ Being regarded as having such an impairment.

A physical or mental impairment includes:

- ✓ Any physiological disorder or condition; or
- ✓ Cosmetic disfigurement; or
- ✓ Anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic skin and endocrine; or
- ✓ Any mental or psychological disorder such as cognitive delays, organic brain syndrome, emotional or mental illness and/or learning disabilities.

**Drug addiction (other than addiction caused by current illegal use of a controlled substance) and alcoholism (other than caused by current use) are covered by these provisions as are cancer, heart disease, HIV, AIDS and temporary disabilities such as broken limbs or pregnancy.

The medical or social service professional or other person certifying the disability and need for a reasonable accommodation IS NOT required to reveal the specific nature and/or severity of the individual's disability.

As a medical/ social service professional or other third party with the knowledge necessary to make a determination, I am able to advise that

(name of patient/client)

qualifies as an individual with a disability as defined above and that the following reasonable accommodation is consistent with the needs associated with his/her disability:

Reasonable accommodation:

Signature of certifying person

Date

Name of certifying person

Title

Please feel free to contact me at the following number if you have any questions:

Approval or Denial of Request for Reasonable Accommodation
(to be completed by housing provider)

To: _____

On the _____ day of _____ 20____, you requested the following reasonable accommodation:

We have:

Approved your request and will provide the following accommodation:

The change will be effective upon receipt of this form.

We will provide the accommodation by the _____ day of _____ 20_____.

Before making the accommodation, we must _____

We anticipate that the change will be made by the _____ day of

_____ 20____, and we will notify you in the case of a delay.

If you have any questions or concerns regarding this accommodation, please contact me immediately.

Denied your request because of the following:

The person requesting the accommodation is not a person with a disability as defined by federal and/or state law, and management is not required to provide you with an accommodation.

The accommodation you requested is not reasonable because:

The accommodation will cost \$ _____ and/or _____ additional hours of staff time. This poses an undue burden on operations.

Other: _____

In reaching this decision, we spoke with the following people: _____

In reaching this decision, we reviewed the following documents: _____

In reaching this decision, we performed the following investigation: _____

If you disagree with this decision or have additional information to provide, you may contact me at the following address and/or telephone number.

Signature

Date

Name: _____ Title: _____

Organization: _____

Address: _____

Telephone Number: _____