Affordable housing as a platform to enhance lives.

Request for Reasonable Accommodation

HOUSING CHOICE VOUCHER PROGRAM

HADC
HOUSING AUTHORITY OF DEKALB COUNTY
1955

246 Sycamore Street, Suite 260, Decatur, GA 30030 • **p** 404.270.2500 **f** 404.270.2643 **www.dekalbhousing.org**

You may utilize this form to request that HADC provide a reasonable accommodation to you, or any member of your household who has a disability, so that you or a member of your household may utilize your residence or any of HADC's facilities, programs or services.

If you would like to request a reasonable accommodation on behalf of yourself or a member of your household, please complete this form. You must date and sign your name at the bottom of this form and return it to the HADC office. You may also email it to reasonableaccommodations@dekalbhousing.org.

If you need assistance in understanding whether you or a member of your household is a "qualified individual with a disability" or if you need assistance in completing this form, please contact HADC.

Date of Request: _____

Name of Applicant/Resident/Participant: _____

I am requesting the reasonable accommodation(s) on behalf of (name):

_____

Telephone Number: _____ **Email Address:** _____

Address: _____ **City/State/Zip:** _____

1. **I am requesting the following reasonable accommodation(s):**

   _____

   _____

2. **My reason(s) for requesting this reasonable accommodation:**

   _____

   _____

A physician, licensed health care professional, or professional representing a social service agency, disability agency, or clinic may provide verification of your disability.

HADC will work with you to determine how to fulfill your reasonable accommodation request(s). Before denying a request, HADC will engage in an interactive process with you or your family, such as requesting more information or documentation from you, as needed.

Signature: _____ **Date:** _____

If you require special assistance or reasonable accommodations due to a disability, including the need to receive documents or communications in alternative formats, please contact the Housing Choice Voucher Program Office at (404) 270-2500. For Georgia Relay Service, dial 7-1-1.

EQUAL HOUSING

TEL: 404-270-2500
FAX: 404-270-2550
HOUSING CHOICE VOUCHER FAX: 404-270-2643
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750 Commerce Drive
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VERIFICATION OF DISABILITY

Participant/Applicant Name: _____

Participant/Applicant ID Number: _____

Requesting Household Member: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing agency to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown above.

INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" or "√" in the applicable box that accurately describes the person listed above.

1. ☐ YES ☐ NO
   Has a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.

2. ☐ YES ☐ NO
   Is a person with a developmental disability, as defined in Section 102(7) of the Developmental Assistance and Bill of Rights Act (421 U.S.C. 6001 (8)), i.e. , a person with a sever chronic disability that:
   - (a) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   - (b) Is manifested before the person attains age 22;
   - (c) Is likely to continue indefinitely
   - (d) Results in substantial functional limitation in three or more of the following areas of major life activity;
     - (1) Self-care,
     - (2) Receptive and expressive language,
     - (3) Learning,
     - (4) Mobility,
     - (5) Self-direction
     - (6) Capacity for independent living, and
     - (7) Economic self-sufficiency; and
   - (e) Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

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3. ☐ YES ☐ NO
Is a person with a chronic mental illness, i.e. he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

4. ☐ YES ☐ NO
Is a person whose sole impairment is alcoholism or drug addiction.

Name of Person Supplying Information (Please Print): _____

Title of Person Supplying Information (Please Print): _____

Firm/Organization Name (Please Print): _____

Firm/Organization Current Address (Please Print): _____

Firm/Organization City, State, Zip Code (Please Print): _____

Office Number: (_____)_____ **Fax Number:** (_____)_____

Email address: _____

Signature of person supplying information: _____

Do Not Write In This Space (For Official HADC Use Only)

Date of Verification of 1st Attempt: _____ *Verified:* ☐ *Yes* ☐ *No*

Date of Verification of 2nd Attempt: _____ *Verified:* ☐ *Yes* ☐ *No*

Date of Verification of 3rd Attempt: _____ *Verified:* ☐ *Yes* ☐ *No*

Request Approved: ☐ *Yes* ☐ *No* *Approval Date:* _____

Request Denied: ☐ *Yes* ☐ *No* *Denial Date:* _____

Date Request Forwarded to Specialist: _____

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CERTIFICATION OF NEED FOR ATTENDANT CARE/AUXILIARY APPARATUS

Participant/Applicant Name: _____

Participant/Applicant ID Number: _____

Requesting Household Member: _____

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the housing agency to verify all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in providing the following information and returning it to the person listed at the top of the page. Your prompt return of this information will help to ensure timely processing of the application for assistance. The applicant/tenant has consented to this release of information as shown above.

INFORMATION BEING REQUESTED

For each numbered item below, mark an "X" or "√" in the applicable box that accurately describes the person listed above.

1. ☐ **YES** ☐ **NO** Does the above person have a disability related need for a Live-In Aide/Attendant?
2. ☐ **YES** ☐ **NO** Is the Live-In Aide/Attendant essential for the care and the well-being of the person?
3. ☐ **YES** ☐ **NO** Does the applicant/tenant require a separate bedroom for medical apparatus or other medically related purpose?

Name of Person Supplying Information (Please Print): _____

Title of Person Supplying Information (Please Print): _____

Firm/Organization Name (Please Print): _____

Firm/Organization Current Address (Please Print): _____

Firm/Organization City, State, Zip Code (Please Print): _____

Office Number: (_____) _____ **Fax Number:** (_____) _____

Email address: _____

Signature of person supplying information: _____

Do Not Write In This Space (For Official HADC Use Only)

Date of Verification – 1st Attempt: _____	*Verified:* ☐ *Yes* ☐ *No*	*Request Approved/Denied*	*Approval/Denial Date:* _____
Date of Verification – 1st Attempt: _____	*Verified:* ☐ *Yes* ☐ *No*	*Request Approved/Denied*	*Approval/Denial Date:* _____
Date of Verification – 1st Attempt: _____	*Verified:* ☐ *Yes* ☐ *No*	*Request Approved/Denied*	*Approval/Denial Date:* _____

Date Request Forwarded to Specialist: _____