

CHANGE.

CHICAGO HOUSING AUTHORITY
Housing Choice Voucher Program

¡Este documento es importante, tradúzcalo inmediatamente!

REASONABLE ACCOMMODATION REQUEST FORM

If you need this document in a different language or format, please call 312.935.2600 or TTY: 312.461.0079. At least five business days' advance notice is required to arrange for interpreter services.

Head of Household Name: _____ Voucher #: _____

Address: _____ City, State & Zip Code: _____

Reasonable Accommodation request completed on behalf of: (Check one of the following.)

Head of Household Family Member: _____
(Name)

SECTION 1: DEFINITION

A reasonable accommodation is a slight change in procedure or policy that enables a person with disabilities to take full advantage of the same housing opportunities as others. According to the Fair Housing Act amended in 1989 and Section 504 of the Rehabilitation Act of 1973—as amended, a person with a disability includes any person who has:

- Physical or mental impairment(s) that substantially limits one or more major life activities;
- Has a record of having such impairments; or
- Is regarded by others as having such impairments.

Examples include, but are not limited to: learning disabilities, diabetes, past drug addiction and alcoholism, emotional illness, cancer, heart disease, AIDS, etc. It does NOT include current, illegal use of or addiction to a controlled substance.

SECTION 2: THIS SECTION TO BE COMPLETED BY THE VOUCHER PROGRAM PARTICIPANT:

Voucher program staff **may** fill in the name, voucher number and requested accommodation on behalf of the participant and must initial and date the request in the spaces provided below. The exception to this rule is when the request is for accommodations related to payment standards, utility allowances or voucher size. When this is the case, the participant **must** fill out and sign this section to authorize the release of information by the physician or health care provider.

The individual, named above, who needs the reasonable accommodation, meets the definition of an individual with a disability as stated above. Yes No

The reasonable accommodation requested for the individual with disability is: _____

I authorize the physician/health care provider named below to release the specific information requested on the next section of this form to The Chicago Housing Choice Voucher Program to verify my request for reasonable accommodation.

Health Care Provider Name: _____ Street address: _____

City, State, Zip Code: _____ Phone number: _____

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or representative of the United States Government.

Signature: _____ Date: _____ *Staff initials: _____
(Signature of Participant) (If applicable)

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SECTION 3: THIS SECTION IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Section 504 of the Rehabilitation Act of 1973 allows The Housing Choice Voucher Program to obtain confirmation that the reasonable accommodation request entered above is consistent with the patient/client's disability. Disability is defined on page one of this form. Please provide the following information concerning your patient's request for a reasonable accommodation. **Please note that this is not a request for medical records or detailed information about the disability.** Please limit your remarks to describing functional limitations and to confirming that the accommodation that is requested above is relevant to this patient/client's case.

As a medical or health care provider with the knowledge necessary to make such a determination,

I, _____, of _____ located at
(Name of Physician or Health Care Provider) (Name of institution or agency)

_____ certify that
(Street Address, City & Zip Code)

_____ qualifies as an individual with a disability as defined on
(Name of Person who needs accommodation)

the first page of this form and that the accommodations that the patient named on this form has requested are consistent with his/her needs associated with his/her disability. The functional limitations caused by said disability are:

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or representative of the United States Government.

I may be contacted at the following phone number: _____

Signature of Physician or Health Care Provider: _____ Date: _____