REQUEST FOR ACCOMMODATION PACKET

This packet contains the forms necessary to request an accommodation from the Housing Authority of the City and County of Denver ("DHA"). In order to help avoid misunderstandings regarding what is being requested or whether a request was made, DHA requires all requests for accommodation to be put in writing. If an individual is unwilling to provide a request in writing, or to sign a request, DHA will document the request and review it based solely on the information provided.

Prior to determining whether the requested accommodation(s) is/are reasonable, your Health Care Provider must verify that your impairment meets the legal definition of disability and that you require the requested accommodation based on your disability. Once you have determined that you require an accommodation, it is your responsibility to ensure that all the necessary forms have been completed and submitted to DHA (forms must be submitted in one complete package, or your request may not be processed), as outlined below:

STEP 1. FORM #1 – REQUEST FOR ACCOMMODATION ("Request"): You must complete this form, indicating which member of the household is disabled (indicate “SELF” if you are the disabled individual). You must also state the accommodation you are requesting. YOU MUST SIGN THIS FORM AS HEAD OF HOUSEHOLD. IF YOU ARE NOT THE DISABLED INDIVIDUAL, THE INDIVIDUAL WHO IS DISABLED MUST ALSO SIGN THE FORM, UNLESS THEY ARE UNDER 18 YEARS OF AGE.

STEP 2. FORM #2 – HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY ("Verification"): You must fill in all lines in Section A of the Verification. After you have filled out Section A, you must take the Verification to your Health Care Provider, along with Form #1 – Request and the Health Care Provider Instruction Sheet (attached). Have your Health Care Provider fill out Section B of the Verification and sign the form. Please ask your Health Care Provider to carefully read the instruction sheet to ensure they complete the form appropriately.

STEP 3. Return Forms 1 and 2, together, to: 504 Coordinator, Denver Housing Authority, 1035 Osage St., 11th Floor, Denver, Colorado, 80204 or by fax at (720) 932-3009.

NOTE: If assistance is required to complete Form 1 or Section A of Form 2, please contact a DHA employee in the department from which you obtained this form (e.g., Occupancy, Section 8 or Development Manager). After this form has been completed, you must take Forms #1 and #2 to your Health Care Provider, DHA will not send this form to your Health Care Provider.

After DHA receives the completed forms, which have been signed by both you and your Health Care Provider, a decision will be made regarding your request. If an individual refuses to sign the form authorizing DHA to contact the Health Care Provider to verify or obtain necessary information, DHA may be unable to verify whether the requested accommodation is necessary based on the individual’s disability and the request may be denied. DHA has twenty (20) business days in which to respond to your request. Please note that DHA makes every attempt to respond promptly, so phone calls regarding the status of your application further delay the review process for all applicants. Any additional information necessary to consider your request will be made in writing. Finally, DHA will send you an approval or denial of your request, in writing.
NOTICE OF AVAILABILITY OF REASONABLE ACCOMMODATION

It is the Housing Authority of the City and County of Denver’s (“DHA”) policy to provide “reasonable accommodation” in housing for applicants, public housing residents, and Section 8 clients with disabilities who are otherwise qualified for DHA’s housing programs. This policy is in furtherance of DHA's goal of providing affordable housing to low-income persons regardless of disability and in compliance with applicable federal, state, and local law.

A person with a disability is one who (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

A “reasonable accommodation” is a modification or change the DHA can make to its rules, policies, practices or services, or modifications to the person’s apartment or to a public/common area where such is necessary to provide a person with a disability an equal opportunity to participate in, or benefit from, DHA housing programs. Examples of a reasonable accommodation include, but are not limited to, the following:

- A transfer to a unit with wheelchair access; or
- Installation of strobe-type flashing light smoke detector in a DHA housing unit for the hearing-impaired; or
- The provision of an appropriate auxiliary aid where such assistance is necessary to enable effective communication between the applicant, public housing resident or Section 8 client and DHA.

If you or a member of your household have a disability and think you need an accommodation, you may request it at any time during the application process or after admission. If you would prefer not to discuss your situation with DHA, and not request an accommodation, that is your right.

You may obtain a Request for Accommodation form from DHA at:

504 Coordinator
1035 Osage Street, 11th Floor
Denver, Colorado 80204

You may also request that the form be sent to you by contacting your Occupancy Interviewer, development manager, or Section 8 Technician, or by logging on to www.denverhousing.org.

If you have questions or problems, please contact the 504 Coordinator, by phone at (720) 932-3091, by fax at (720) 932-3009, or by mail at 1035 Osage St., 11th Floor, Denver, Colorado, 80204.

NOTICE OF AVAILABILITY OF ALTERNATIVE FORMS OF COMMUNICATION

If you have a disability and require an alternative form of communication including, but not limited to, sign-language interpreter or assistance completing forms, you may make your request at any time during the application process or after admission by completing the “Request for an Alternative Form of Communication” form. ALTERNATIVE FORMS OF COMMUNICATION DO NOT INCLUDE THE PROVISION OF A FOREIGN LANGUAGE INTERPRETER.

Este es un documento importante. Para obtener asistencia gratuita con el idioma, contáctese con el Departamento de Sección 8, el Departamento de Ocupación o la División de Administración de Vivienda.
FORM #1
REQUEST FOR ACCOMMODATION
DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

Este es un documento importante. Para obtener asistencia gratuita con el idioma, contáctese
con el Departamento de Sección 8, el Departamento de Ocupación o la División de
Administración de Vivienda.

This form and the completed Health Care Provider Verification Form #2 must be submitted
to the 504 Coordinator, at 1035 Osage Street, 11th Floor, Denver, Colorado 80204, or by fax at
(720) 932-3009.

NAME: ____________________________________  TELEPHONE NO.: _________________________

ADDRESS: _____________________________________________________________________________

CITY, STATE, ZIP CODE: ____________________________________________

PROGRAM: PUBLIC HOUSING: ______  SECTION 8: ______  ARE YOU AN APPLICANT? ☐ YES ☐ NO

□ REQUIRED INFORMATION: The following member of my household has a disability, i.e., a
physical or mental impairment that substantially limits one or more life activities.
Name: ___________________________ Date of Birth: ___________________________
Relationship or association with you: ________________________________________

□ (If applicable) I authorize the Housing Authority of the City and County of Denver (“DHA”) to
contact the following individual who assisted me in the completion of this form:
Name: ___________________________ Telephone: ___________________________
Address: _____________________________________________________________________________

City, State, Zip Code: ________________________________________________________________

□ REQUIRED INFORMATION: I authorize DHA to verify that I have a disability and need the
accommodation I have requested. In order to verify this information, DHA may contact the
following Health Care Provider:
Name: ___________________________
Title of Health Care Provider: ___________________________
Agency, Facility or Institution (if any): ___________________________
Address: _____________________________________________________________________________

City, State, Zip Code: ________________________________________________________________

Telephone: _______________ Fax: (required) ___________________________

□ I authorize the Health Care Provider to release any information necessary to assess the request
for an accommodation(s) I have made including the information requested in Form #2 to DHA.

Signed: ___________________________ Date: ___________________________
(Head of Household or Authorized Representative)

Signed: ___________________________ Date: ___________________________
(Individual with the Disability, if Over 18)

NOTE: DHA REQUESTS THE INFORMATION ABOVE IN THE EVENT ADDITIONAL
INFORMATION IS NECESSARY TO CONSIDER YOUR REQUEST. YOU MUST HAVE YOUR
HEALTH CARE PROVIDER COMPLETE FORM #2 – HEALTH CARE PROVIDER VERIFICATION
FORM ATTACHED TO THIS REQUEST.
I understand that the information obtained by DHA will be kept completely confidential, to the extent permitted by law, and used solely to make a determination regarding my accommodation request.

- **REQUIRED INFORMATION**: As A Result Of This Disability, I Am Requesting The Following Accommodation: (Please check one or more boxes below):
  
  - [ ] **A change in my apartment or the public or commons areas of the housing development (Public Housing Residents Only)**. Please explain why the requested change is necessary and specifically state the change you are requesting:

  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________

  - [ ] **An exception to a rule, policy, practice or service**. (You may request a change that you believe will allow you to comply with the terms of the lease or voucher, but everyone is required to comply with the essential terms of their lease or the voucher program.) Please explain why the exception you are requesting is necessary, and specifically identify the exception you want DHA to make:

  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________

  - [ ] **Other** (for example, a change in the way DHA communicates with you). Please specify:

  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________

  - [ ] **A Live-in Aide**. If you are requesting an additional bedroom to accommodate a Live-In Aide please answer the following questions:

    1. Is the proposed Live-In-Aide a relative/spouse/domestic partner/common law spouse/boyfriend/girlfriend/significant other of the Applicant?

       [ ] YES   [ ] NO

    2. Your proposed Live-In-Aide would not otherwise be living in the home except to provide the necessary supportive services?

       [ ] YES   [ ] NO

    3. Please provide the name of the proposed Live-In-Aide and explain the relationship between the Live-in-Aide and the Applicant.

       Name: ________________________________

       Relationship: ________________________________
4. Does the proposed Live-In-Aide currently live with Applicant?
   [ ] YES    [ ] NO  If you marked NO, please provide the Live-in-Aide’s current address:
   Address: ____________________________________________

5. Has the proposed Live-In-Aide ever lived with Applicant?
   [ ] YES    [ ] NO  If you marked YES, please explain in detail:
   ______________________________________________________

   Will the Live-In-Aide be paid to provide health and/or supportive care services?
   [ ] YES    [ ] NO

6. Will the Applicant’s address be the only residence of the proposed Live-In-Aide?
   [ ] YES    [ ] NO
   If you marked NO, please explain how many nights a week the Live-In-Aide will stay with
   the Applicant:
   ______________________________________________________

7. Is the proposed Live-In-Aide working full-time or going to school full-time?
   [ ] YES    [ ] NO  If you marked YES, please explain in detail:
   ______________________________________________________

   **REQUIRED INFORMATION:**  *This Accommodation Is Necessary So That I Can:* (Please state how
   the accommodation will provide you with an equal opportunity to participate in, or benefit
   from, DHA housing programs.)
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

Signed: ___________________________    Date: ___________________________
   (Head of Household or Authorized Representative)

Signed: ___________________________    Date: ___________________________
   (Individual with the Disability, if Over 18)
INFORMATION SHEET FOR COMPLETING THE HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY FORM

The Housing Authority of the City and County of Denver ("DHA") is a federally funded program. Therefore, the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act of 1973 ("Section 504") require DHA to provide reasonable accommodations to qualified program applicants or participants of the Section 8 and public housing programs (herein referred to as “Applicant”). DHA may verify that the requested accommodation is necessary to give the Applicant an equal opportunity to participate in, or benefit from, DHA housing programs. DHA has implemented a process to review requests for accommodations submitted by the Applicant. The attached form provides DHA with verification of the Applicant's disability, and the necessity of the requested accommodation.

DHA may also verify the Applicant's disability only to the extent necessary to ensure that the Applicant has a need for the requested accommodation. Therefore, **DO NOT** provide medical records, or specify the Applicant's disability, or provide any specific details about the nature of the disability in your response. DHA requires documentation of the manifestation of the disability that causes a need for the requested accommodation.

WHAT QUALIFIES AS A DISABILITY?

A person with a disability is one who:

1. Currently has a physical or mental impairment that substantially limits one or more major life activities; or
2. Has a record of such an impairment; or
3. Is regarded as having such impairment.

This definition may differ from the medical definition of "disability." However, this is how “disability” is defined by the ADA and Section 504, and is the definition you **must** use in evaluating and certifying whether the Applicant meets the definition of a person with a “disability.” You **must** strictly interpret and apply this legal definition. The key words in this definition are, “substantially limits” one or more “major life activities.”

The term “substantially limits” shall be interpreted consistently with the findings and purposes of the ADA. An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability. An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active. (i) The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as (I) medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; (II) use of assistive technology; (III) reasonable accommodations or auxiliary aids or services; or (IV) learned behavioral or adaptive neurological modifications. (ii) The ameliorative effects of the mitigating measures of ordinary eyeglasses or contact lenses shall be considered in determining whether an impairment substantially limits a major life activity.

It is not possible to include a list of all the specific conditions or diseases that would or would not constitute a physical or mental impairment because of the difficulty of ensuring the comprehensiveness of such a list; however below are some qualifying mental and physical impairments, and a list of some of the exclusions under the law.

Qualifying Mental and Physical Impairments:

1. A mental impairment includes, but is not limited to, mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
2. A physical impairment includes, but is not limited to, cosmetic disfigurement; anatomical loss affecting the neurological, musculoskeletal, sensory, respiratory, cardiovascular, or reproductive, digestive, genito-urinary, hemic, lymphatic or skin systems; or AIDS or HIV Positive.
3. A mental or physical impairment includes, but is not limited to, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, alcoholism or drug addiction.

Exclusions from protection:
The following disabilities are explicitly excluded from the definition of disability:

1. Sexual behaviors or traits such as homosexuality, bisexuality, transvestitism, voyeurism, transsexualism, and gender identity disorders not resulting from physical impairments.
2. Compulsive gambling, kleptomania and pyromania.
3. Psychoactive substance use disorders resulting from current illegal use of drugs.

However, a diagnosis of an impairment alone is not determinative of whether an Applicant is disabled. As explained below, the impairment must severely restrict one or more of the Applicant’s major life activities. As the Applicant’s Health Care Provider, you must provide DHA information regarding how severely the Applicant’s major life activities are affected by their impairment. For example, an Applicant diagnosed with an impairment of diabetes may or may not be disabled. If the Applicant has lost their eye sight because of the diabetes, they may be disabled because their major life activity of seeing is substantially limited by the impairment of diabetes. On the other hand, if the Applicant simply has to monitor their glucose levels and the diabetes does not substantially limit their major life activities they are not disabled.

**WHAT QUALIFIES AS A “MAJOR LIFE ACTIVITY”?**

“Major life activity” refers to those activities that are of central importance to most people’s daily lives. The tasks in question must be central to daily life. It is insufficient for Applicants attempting to prove disability status under the ADA or 504 to merely submit evidence of a medical diagnosis of an impairment. Instead, to prove a disability they must offer evidence that their performance of a major life activity is severely restricted as to condition, manner, or duration under which such activity can be performed in comparison to the average person in the general population.

**WHAT DOES “REGARDED AS HAVING SUCH AN IMPAIRMENT” MEAN?**

A person is “regarded as” disabled within the meaning of the ADA if: (1) a covered entity mistakenly believes that a person has an impairment that substantially limits one or more major life activities, or (2) a covered entity mistakenly believes that the person’s actual, non-limiting impairment substantially limits one or more major life activities. As a recipient of federal funds, DHA is a covered entity. The fact that DHA is engaged in this process with the Applicant is evidence that DHA does not mistakenly believe that the Applicant has an impairment that limits one or more major life activities. Nor does DHA mistakenly believe that the Applicant’s actual, non-limiting impairment substantially limits one or more major life activities. Note that this definition specifically states that the covered entity (i.e., DHA) must have the mistaken belief, not a physician, other members of the community, or other entities.

**WHAT IS A REASONABLE ACCOMMODATION?**

A reasonable accommodation is a modification to an Applicant’s unit, common or public areas of the facility, or a change in rules, policies, practices or services that will allow a person with a disability to have an equal opportunity to participate in, or benefit from, DHA housing programs.

An accommodation is not reasonable, simply because the Applicant is disabled. The accommodation must be reasonable and there must be an identifiable relationship, or nexus, between the requested accommodation and the Applicant’s disability. Therefore, you must provide your professional opinion and certify as to why the requested accommodation is necessary in order for the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs, because of the Applicant’s disability.

On the attached form you must:

1. specifically identify the major life activities that are affected by the Applicant’s disability;
2. describe how these major life activities are substantially affected by the Applicant’s disability; and
3. explain how the accommodation is directly related to the Applicant’s disability.

**PLEASE RETURN FORM #2 – HEALTH CARE PROVIDER VERIFICATION FORM, TO THE APPLICANT. THEY MUST SUBMIT THIS FORM, WITH THEIR REQUEST FOR ACCOMMODATION TO DHA. IF ADDITIONAL INFORMATION IS REQUIRED, DHA WILL CONTACT YOU DIRECTLY.**
FORM #2
HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY

DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

SECTION A

Applicant’s Name: ________________________________________________

Address: ________________________________________________________

(Street Address, City, State, Zip Code)

Requested Accommodation: _______________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

SECTION B

The person named above is an Applicant for an accommodation because of disability, and is requesting that DHA provide them with the accommodation stated in Section A above. After you have completed this form, please return it to the Applicant, so they may submit the necessary forms to DHA for their request to be considered.

Health Care Provider must fill in all appropriate blanks below in this Section B. DO NOT ATTACH ANY MEDICAL RECORDS OR OTHER DOCUMENTATION REGARDING THE INDIVIDUAL’S DISABILITY. You must address these issues in your answers to the questions below. DHA cannot and will not interpret documentation regarding an individual’s disability to determine if their disability requires the requested accommodation. As the Health Care Provider it is your responsibility to provide the necessary information regarding the individual’s disability and how that disability is related to their Request for Accommodation. Before you complete this form, please read the attached information sheet so that you clearly understand what an accommodation is and how the law defines "disabled.” If a question is not applicable write “N/A” next to the question.

Please note that a health care provider is not required to use Form #2. Alternatively, a health care provider may submit a letter supporting the Applicant’s request. Please be advised this letter must state with sufficient clarity: (1) whether the Applicant qualifies as disabled as described below; (2) what accommodation is requested; and (3) must describe the relationship, or nexus, between the requested accommodation and the Applicant’s disability.

Name of Health Care Provider: __________________________________________

Agency, Facility or Institution (if any): ________________________________

Address: ________________________________________________________

City, State, Zip Code: _____________________________________________

Telephone: __________________________ Fax: (required) ___________
1. In my opinion, the Applicant has a disability as defined below. Please check any paragraph below that applies. **(If none of these apply, please go to Question 2)**
   - [ ] A. A physical or mental impairment that substantially limits one or more major life activities.
   - [ ] B. A record of having such an impairment. If you check this box answer the following question:
     (i) Identify the covered entity that has a record of the Applicant having an impairment that substantially limits one or more major life activities.
   - [ ] C. Is regarded as having such an impairment. If you check this box answer the following question:
     (i) Identify the covered entity that mistakenly believes that the Applicant either has: 1) an impairment that substantially limits one or more major life activities; or, 2) an actual non-limiting impairment substantially limits one or more major life activities.

2. [ ] In my opinion this individual does not qualify as disabled as discussed above. **(Please go to the end of this form, read the certification and sign the bottom of this form.)**

3. Specifically identify the “major life activities” that are affected by the Applicant’s physical or mental impairment. How often is the listed “major life activity” performed (daily, weekly, monthly, etc.)?

4. State, in detail, how the Applicant is significantly restricted in the condition, manner or duration under which he/she can perform the major life activities identified in Question 3, compared to the average person in the general population.

5. Does the Applicant have available to them any alternatives that would provide a similar accommodation for the Applicant’s disability?
   - [ ] YES
   - [ ] NO
   If YES, please explain: ___________________________________________________________
6. Will the Applicant require the accommodation permanently?

[ ] YES (Go to 7 below) [ ] NO [ ] UNKNOWN

A. If the required length of the accommodation is unknown when will the required length be determined?

B. If the disability status is unknown, when will the Applicant’s disability status be determined?

How long will the Applicant be disabled?

7. In my opinion, the Applicant’s disability requires that one or more of the following accommodation(s) be made in order for the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs:

(a) An extra bedroom for medical equipment, please go to question 8.

(b) A Live-in Aide, please go to question 9.

(c) An Assistance Animal, please go to question 10.

(d) A unit with specific features (i.e. grab bars, no/limited stairs, handicapped accessible), please go to question 11.

(e) Other, please answer A through D below.

[ ] NO (Please go to the end of this form, read the certification and sign below)

A. Specifically identify the accommodation(s) required.

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

B. Why does the Applicant need the requested accommodation(s)?

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

C. How is this accommodation(s) directly related to the Applicant’s disability?

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
D. How will the requested accommodation(s) enable the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

8. If the Applicant is requesting an extra bedroom to store medical equipment, please respond to the following questions:

A. Have you prescribed the medical equipment for the Applicant?
   [ ] YES  [ ] NO

B. Does the Applicant need medical equipment that requires storage in a separate location, other than the living room, bathroom, kitchen, or Applicant’s bedroom(s)?
   [ ] YES  [ ] NO

C. List all medical equipment the Applicant has at home and the approximate size of the equipment.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

D. Why must the Applicant store this equipment in a separate bedroom, instead of another room of the unit?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

E. Where does the Applicant use the medical equipment? How often is it used?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

F. Identify the relationship, or nexus, between the Applicant’s request for an additional bedroom, the need for the medical equipment, and the Applicant’s disability.

_________________________________________________________________
_________________________________________________________________
9. Federal regulations require DHA to allow, as a reasonable accommodation, a qualified person with a disability to have a Live-in Aide (also referred to as a personal care provider, caregiver, nurse etc.) and approve one (1) additional bedroom for the Live-In Aide. A Live-In Aide is a 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 person(s); (2) is not obligated for the support of the person(s); and, (3) would not be living in the unit except to provide the necessary supportive services. DHA is also obligated to provide an extra bedroom for a Live-in Aide.

By definition a Live-in Aide cannot be the boyfriend/girlfriend, spouse, partner, or any other individual who otherwise would be living with the Applicant.

Because a Live-in Aide’s income is not considered when determining the Applicant’s rental obligation it is important to verify that there is an arm’s length transaction in the Live-in Aide relationship.

A. Has the Applicant informed you that the proposed Live-in Aide would not otherwise be living in the home except to provide the necessary supportive services?
   [ ] YES   [ ] NO

B. Does the Applicant have a disability that requires a Live-in Aide?
   [ ] YES   [ ] NO
   If yes, please explain in detail:
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

C. The Live-In-Aide will provide health and/or supportive care services as follows:
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

D. Does the Applicant have a disability that requires a Live-in Aide?
   The health and/or supportive care services are needed:
   [ ] FUL-TIME   [ ] PART-TIME
   If Part-time, what hours of the day? From____________ to ________________
E. How many nights a week are the health and/or supportive services needed?

_________________________________________________________________
_________________________________________________________________

F. A daily in-home worker is not equally effective as a reasonable alternative accommodation (i.e. why does the Applicant need someone to stay the night at the property?) because:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

10. Federal regulations require DHA to allow, as a reasonable accommodation, a qualified person with a disability to own and keep an “assistance animal” (also referred to as a service animal or companion animal), on DHA’s premises. An assistance animal is an animal that works, provides assistance, or performs tasks for the benefit of a person with a disability; or animal that provides emotional support that alleviate one or more identified symptoms or effects of a person’s disability. If the Applicant is requesting that they be allowed to keep an assistance animal, please answer the following questions:

A. Were you aware that DHA allows its residents to have one (1) pet (with certain breed and size restrictions) with a refundable pet deposit of $100 and a nonrefundable $50.00 fee? This policy does not apply to assistance animals that assist persons with disabilities.

[ ] YES  [ ] NO

B. Does the Applicant require an assistance animal as defined above?

[ ] YES  [ ] NO

C. Identify the relationship, or nexus, between the Applicant’s request for an assistance animal and the Applicant’s disability and explain how the animal doesn’t meet the traditional definition of a “pet”.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

11. Please explain what features are required as related to the Applicant’s disability. What specific features are needed?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
Does the Applicant require a handicapped accessible unit?

[ ] YES  [ ] NO

I HEREBY CERTIFY THAT I HAVE READ THE INFORMATION SHEET FOR COMPLETING “FORM #2 – HEALTH CARE PROVIDER’S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY” AND I UNDERSTAND ITS CONTENTS. I FURTHER CERTIFY THAT ALL INFORMATION I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT. FINALLY, I UNDERSTAND THAT I CAN BE SUBPOENED TO TESTIFY IN ANY TRIALS OR HEARINGS RELATED TO THE APPLICANT’S REQUEST.

__________________________________________  ______________________
Signature of Health Care Provider                 Date

WARNING: THERE ARE FINES AND IMPRISONMENT -- $250,000/5 YEARS -- FOR ANYONE WHO MAKES FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR ENTRIES IN ANY MATTER WITHIN THE JURISDICTION OF THE FEDERAL GOVERNMENT (18 USC 1001). IN ADDITION, ANY PERSON WHO KNOWINGLY AND MATERIALLY VIOLATES ANY REQUIRED DISCLOSURE OF INFORMATION, INCLUDING INTENTIONAL NON-DISCLOSURE, IS SUBJECT TO CIVIL MONEY PENALTY NOT TO EXCEED $10,000 FOR EACH VIOLATION.

Thank you. If you have any questions, please contact the 504 Coordinator, by phone at (720) 932-3091, by fax at (720) 932-3009, or by mail at 1035 Osage St., 11th Floor, Denver, Colorado, 80204.