

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”). Please read the “Notice of Availability of Reasonable Accommodation” prior to completing these forms, as well as the enclosed “Request for Accommodation” form and the “Health Care Provider’s Verification of Need for an Accommodation in Housing Because of a Disability” form.

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. **NOTE: IF YOU ARE UNABLE TO TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER, PLEASE RETURN TO DHA AND WE WILL FORWARD TO YOUR HEALTH CARE PROVIDER.**
- STEP 3. Return Forms 1 and 2, together, to: Meichell Walsh, Denver Housing Authority, 777 Grant St., 4th Floor, Denver, Colorado 80203.

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. DHA has 45 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 services. 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, such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and working; (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 different unit with wheelchair access;
- Installation of strobe-type flashing light smoke detector in a DHA housing unit for the hearing-impaired;

A reasonable accommodation may also include 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, in writing, 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:

777 Grant Street
Denver, Colorado 80203
or
Mailing Address:
P.O. Box 40305
Mile High Station
Denver, Colorado 80204-0305

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.dhanet.com.

If you have questions or problems, please contact the 504 Coordinator, Meichell Walsh, at the address above.

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 aviso importante. Por favor hagala traducir inmediatamente.)

FORM #1
REQUEST FOR ACCOMMODATION

DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

NAME: _____ TELEPHONE NO.: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

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

1. The following member of my household has a disability, *i.e.*, a physical or mental impairment that substantially limits one or more life activities such as caring for one's self, doing manual tasks, walking, seeing, hearing, breathing, learning and working.

Name: _____

Relationship or association with you: _____

2. As a result of this disability, I am requesting the following accommodation: (Please check one or more boxes below):

PUBLIC HOUSING RESIDENTS ONLY: A change in my apartment or the public or commons areas of the housing development. 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:

3. 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.)

4. 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 medical or mental health professional, or licensed service agency whose function is to provide services to the disabled, or other expert in the field of: _____

REQUIRED INFORMATION:

Name: _____

Title of Professional or Expert: _____

Agency, Facility or Institution (if any): _____

Address: _____

City, State, Zip Code: _____

Telephone: _____ Fax: (required) _____

NOTE: DHA REQUIRES THE INFORMATION ABOVE, IN CASE ADDITIONAL INFORMATION IS NECESSARY TO CONSIDER YOUR REQUEST. PLEASE PROVIDE THE REQUESTED INFORMATION ONLY FOR THE INDIVIDUAL WHO COMPLETED FORM #2 – HEALTH CARE PROVIDER VERIFICATION FORM YOU ARE SUBMITTING WITH THIS REQUEST. YOU MUST HAVE YOUR HEALTH CARE PROVIDER COMPLETE FORM #2 – HEALTH CARE PROVIDER VERIFICATION FORM ATTACHED TO THIS REQUEST.

Complete the following, if applicable.

I authorize DHA to contact the following individual who assisted me in the completion of this form:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

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. I further understand that DHA will not process my request if this form is incomplete or has been altered, or does not have my original signature.

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

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

This form and the completed Health Care Provider Verification form must be submitted to the 504 Coordinator, Meichell Walsh, at P. O. Box 40305, Mile High Station, Denver, CO 80204-0305.

If you have any questions regarding this form, please contact your Occupancy Interviewer, development manager or Section 8 Technician.

(Este es un aviso importante. Por favor hagala traducir inmediatamente.)

**PLEASE READ THIS SHEET BEFORE COMPLETING
THE ATTACHED FORM.**

**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"). The ADA and Section 504 require that, DHA 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, such as caring for one's self, doing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working; 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 United States Supreme Court has ruled that a person is "substantially limited" in performing a major life activity only if the impairment, on a permanent or long-term basis, prevents or severely restricts the Applicant from engaging in certain major life activities. A major life activity is "substantially limited" if the Applicant is unable to perform a particular life activity that the average person in the general population can perform, or is significantly restricted in "the condition, manner, or duration" under which he/she can perform a particular life activity as compared to an average person in the general population. If the impairment interferes only in a minor way or for a short period of time with the performance of a stated major life activity, the Applicant is not disabled because the impairment is not "substantially limiting."

Based on this definition, it is clear that any number of impairments, such as arthritis, carpal tunnel syndrome, etc., may not fall within the legal definition of "disability," in which case the Applicant is not qualified for an accommodation. Physical or mental impairment does not include simple physical characteristics such as blue eyes or black hair, nor does it include environmental, cultural, economic or other disadvantages such as having a prison record. Your role, as the health care provider, is to provide DHA with your medical opinion regarding whether the Applicant's current impairment meets the legal definition.

**PLEASE READ THIS SHEET BEFORE COMPLETING
THE ATTACHED FORM.**

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 activity(ies). As the Applicant's Health Care Provider, you must provide DHA information regarding how severely the Applicant's major life activity(ies) 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. This includes such basic abilities as breathing, walking, seeing, sleeping, hearing, and performing manual tasks. 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. For example, a person who can walk for 10 miles is not substantially limited in walking merely because, on the eleventh mile, he/she begins to experience pain because the average person in the general population would not be able to walk eleven miles without experiencing some discomfort.

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

**PLEASE READ THIS SHEET BEFORE COMPLETING
THE ATTACHED FORM.**

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. For example, if the Applicant is requesting that grab bars be installed in the bathtub, you could state that, "Patient requires grab bars because he/she lacks flexibility and grab bars would provide them stability in entering and exiting the bathtub."

MEDICALLY NECESSARY

"Medically Necessary" are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not for the convenience of the patient, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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;
3. explain how the accommodation is directly related to the Applicant's disability; and
4. describe any corrective measures that would mitigate the 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. DHA WILL VERIFY, BY FAX, THAT YOU HAVE COMPLETED FORM #2 – HEALTH CARE PROVIDER VERIFICATION. PLEASE NOTE THAT DHA CANNOT BEGIN PROCESSING THE APPLICANT'S REQUEST FOR REASONABLE ACCOMMODATION UNTIL DHA RECEIVES YOUR FAX VERIFICATION.

FORM #2
DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY
HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR A
REASONABLE ACCOMMODATION BECAUSE OF A DISABILITY
REQUEST TO INCREASED UNIT TEMPERATURE

SECTION A

Applicant's Name: _____

Address: _____
(Street Address, City, State, Zip Code)

I authorize the Health Care Provider to release the medical information requested below to the Housing Authority of the City and County of Denver ("DHA"), and any other information necessary to assess the Applicant's request for an accommodation(s).

Signature: _____ Date: _____

Applicant must fill in all blank lines above in this Section A, and sign on the line above and date. Then take this form to your Health Care Provider so that he/she can complete Section B below. NOTE: IF BOTH SECTIONS A AND B HAVE NOT BEEN COMPLETED, YOUR REQUESTED ACCOMMODATION WILL BE DENIED.

SECTION B

Health Care Provider must fill in all appropriate blanks below in this Section B. 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.

Health Care Provider's Name (please print clearly)

Street Address

City, State and Zip Code

Telephone Number

Fax Number

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.

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, such as caring for one’s self, doing manual tasks, walking, seeing, hearing, breathing, learning and working.

B. A record of having such an impairment. If you check this box answer the following questions:

(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 and/or monthly)?

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 currently utilize, or have available to them, any medication, apparatus, or other corrective measures that would mitigate the disability?

YES **NO**

If yes, please explain in detail: _____

6. Does the Applicant have available to them any medication, apparatus, or other corrective measures that would provide a similar accommodation for the Applicant's disability (i.e., utilizing sleep aides or ear plugs to reduce disturbance by spouse during the night)?

YES **NO**

If yes, please explain in detail: _____

7. Is the disability permanent?

YES (Go to 8 below)
 NO (Answer A below)
 UNKNOWN (Answer B below)

A. If the disability is temporary, how long will the Applicant be disabled?

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

How long will the Applicant be disabled? _____

8. In my opinion, the Applicant's disability requires an accommodation that the temperature in their unit be raised from a maximum of 72° to _____°F in order for the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs.

YES (Please respond to each of the following questions.)

NO (Please go to the end of this form, read the certification and sign the bottom of this form.)

A. How is raising the temperature above 72° directly related to the Applicant's disability?

B. How will raising the temperature above 72° enable the Applicant to have an equal opportunity to participate in, or benefit from, DHA housing programs?

C. Is raising the temperature from 72° medically necessary? Medically necessary is defined as procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment,

would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

YES

NO

I HEREBY CERTIFY THAT I HAVE READ THE INFORMATION SHEET FOR COMPLETING THE "HEALTH PROVIDER'S VERIFICATION OF EMPLOYEE NEED FOR A REASONABLE ACCOMMODATION BECAUSE OF A DISABILITY" FORM AND I UNDERSTAND ITS CONTENTS. I FURTHER CERTIFY THAT ALL INFORMATION I PROVIDED IN THIS FORM IS ACCURATE, COMPLETE, AND CURRENT. FINALLY, I AGREE TO TESTIFY AT ANY TRIALS OR HEARINGS AS REQUIRED BY DHA AND I UNDERSTAND THAT I CAN BE SUBPOENAED TO TESTIFY IN ANY SUCH TRIALS OR HEARINGS.

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.

NOTE: YOU MUST SEND YOUR RESPONSE WITH AN ORIGINAL SIGNATURE TO DHA, IN ORDER FOR DHA TO CONSIDER YOUR PATIENT'S REQUEST.

Signature of Health Provider (*please sign with blue ink*)

Thank you. If you have any questions, please contact the 504 Coordinator, Meichell Walsh, at (720) 932-3144; TDD (720) 932-3111; or Colorado Relay TDD (800) 659-2656; P. O. Box 40305, Mile High Station, Denver, CO 80204-0305.