FORM #1
REQUEST FOR ACCOMMODATION
DO NOT RETYPE OR ALTER THIS FORM IN ANY WAY

You must complete this section as shown. Under **APPLICANT** Check **YES** or **NO**

NAME: Jane Doe **TELEPHONE NO.:** 303-456-7890

ADDRESS: 1234 Anywhere St.

CITY, STATE, ZIP CODE: Denver, CO 80203

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

Complete if individual with disability is someone other than head-of-household

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: John Doe

   Relationship or association with you: son

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.

   Please install grab bars in the bathroom

   ☐ 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:______

You must respond to this question by checking one of these boxes and stating what accommodation you are requesting.

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.)

   My son needs extra support to get in the bathtub safely

You must explain why you require an accommodation

SAMPLE

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: ____

____

You must fill in all of these blanks.

REQUIRED INFORMATION:

Name: Dr. Anybody

Title of Professional or Expert: Physician

Agency, Facility or Institution (if any): ____________________

Address: 1234 Someplace

City, State, Zip Code: Denver, CO 80123

Telephone: 303-567-8901 Fax: (required) 303-567-8902

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:

This section is optional.

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.

You must sign here, and if the individual with the disability is not you, they must sign if they are over 18 yeas old. IF YOU DO NOT SIGN, YOUR REQUEST WILL NOT BE PROCESSED

Signed: ____________________ Date: 1/30/06
(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.)

SAMPLE