REQUEST FOR ACCOMMODATION PACKET

This packet contains the forms that may be used to request an accommodation from the Housing Authority of the City and County of Denver ("DHA"). To help avoid misunderstandings regarding what is being requested or whether a request was made, DHA prefers all requests for accommodation to be put in writing. Although a reasonable accommodation request can be made verbally or in writing, it is usually helpful for both the individual and DHA if the request is made in writing.

If an individual's disability is obvious or otherwise known to a representative of DHA, and if the need for the requested accommodation is readily apparent, DHA will document this information on DHA's **Report of Verbal Request for Accommodation/Obvious Disability and Observed Need** form.

If an individual does not wish to, is unable to provide a request in writing, or requires assistance in completing a request for accommodation, they should contact DHA and a staff member will assist the individual by completing the appropriate forms; however, it is requested the individual sign the forms, if possible, to avoid any misunderstandings. DHA will document the request and review it based on the readily available information.

When the disability and the need for the requested accommodation is not readily apparent, prior to determining whether the requested accommodation(s) is/are reasonable, your Health Care Provider (a medical professional, a peer support group, a non-medical service agency, or a reliable third party) who is in a position to know about your disability 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 request one.

Please note that you are not required to use DHA's forms. Alternatively, a health care provider may submit a letter supporting your request. Please be advised this letter must state with sufficient clarity: (1) whether you qualify as disabled; (2) what accommodation is requested; and (3) must describe the relationship, or nexus, between the requested accommodation and your disability.

STEP 1. FORM #1 – REQUEST FOR ACCOMMODATION ("Request"): You may complete this form, indicating which member of the household is disabled (indicate "SELF" if you are the disabled individual) and state the accommodation you are requesting. DHA requests that you sign this form.

STEP 2. FORM #2 – HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY ("Verification"): Please fill in all lines in Section A of the Verification. After you have filled out Section A, 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.

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

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).

If an individual does not 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 includes individuals (1) with a physical or mental impairment that substantially limits one or more major life activities; (2) who are regarded as having such an impairment; or (3) individuals with a record of such an impairment.

A "reasonable accommodation" is a modification or change 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.

If your disability is obvious or otherwise known to a representative of DHA, and if the need for the requested accommodation is readily apparent, DHA will not need such documentation. DHA Staff will record the request using its Report of Verbal Request for Accommodation/Obvious Disability and Observed Need.

If you or a member of your household have a disability and need an accommodation, you may request it at any time during the application process or after admission. Although a reasonable accommodation request can be made at any time orally or in writing, it is usually helpful for both the individual and DHA if the request is made in writing. 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 or Colorado Relay TDD (800) 659 2656, by fax at (720) 932-3009, by mail at 1035 Osage St., 11th Floor, Denver, Colorado, 80204, or by email at LegalDepartment@denverhousing.org.

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 verbally or in writing during the application process or after admission. **ALTERNATIVE FORMS OF COMMUNICATION DOES 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 may be submitted to the 504 Coordinator, at 1035 Osage Street, 11th Floor, Denver, Colorado 80204, by fax at (720) 932-3009 or by email at LegalDepartment@denverhousing.org.

NAME: _____ **TELEPHONE NO.:** _____

ADDRESS: _____ **EMAIL:** _____

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. 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. PLEASE 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 common 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:

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

7. 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:

8. 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)

This is to certify that the information provided on this form is true and correct to the best of my knowledge and recollection. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

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 individuals 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.

DHA may 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.**

WHO IS A HEALTH CARE PROVIDER?

A doctor or other medical professional, a peer support group, a non-medical service agency, or a reliable third party who is in a position to know about the Applicant's disability.

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.

However, a diagnosis of an impairment alone is not determinative of whether an Applicant is disabled. As explained below, the impairment must substantially limit one or more of the Applicant's major life activities. As the Applicant's Health Care Provider, you must provide DHA information regarding how significantly the Applicant's major life activities are affected by their impairment.

WHAT QUALIFIES AS A "MAJOR LIFE ACTIVITY"?

The term "major life activity" means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for oneself, learning, and speaking. This list of major life activities is not exhaustive. "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 provide a medical diagnosis of an impairment. Instead, to verify a disability they must show that their performance of a major life activity is severely restricted as to condition, manner, or duration in comparison to the average person in the general population.

WHAT IS A REASONABLE ACCOMMODATION?

A "reasonable accommodation" is a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces. Since rules, policies, practices, and services may have a different effect on persons with disabilities than on other persons, treating persons with disabilities the same as others will sometimes deny them an equal opportunity to use and enjoy a dwelling. DHA is obligated to make reasonable accommodations to rules, policies, practices, or services when such accommodations may be necessary to afford persons with disabilities an equal opportunity to use and enjoy a dwelling.

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 as to why the requested accommodation is necessary 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 should:

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.

FORM #2

HEALTH CARE PROVIDER'S VERIFICATION OF NEED FOR AN ACCOMMODATION IN HOUSING BECAUSE OF A DISABILITY

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 fax to (720) 932-3009 or email at LegalDepartment@denverhousing.org or return it to the Applicant, so they may submit the necessary forms to DHA for their request to be considered.

Health Care Provider should 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. 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 request. Please be advised this letter must state with sufficient clarity: (1) whether the Applicant qualifies as disabled; (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: _____

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.

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 they 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 <u>size</u> 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:

[ ] **FULL-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 two (2) pets (only restriction is that Pit Bulls must have a city issued breed-restricted permit) with a refundable pet deposit of $100 for each pet? 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 specific features are needed as related to the Applicant's disability:

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.

Signature of Health Care Provider Date

Thank you. If you have any questions, please contact the 504 Coordinator, by phone at (720) 932-3091 or Colorado Relay TDD (800) 659 2656, by fax at (720) 932-3009, by mail at 1035 Osage St., 11th Floor, Denver, Colorado, 80204 or by email at LegalDepartment@denverhousing.org.