

**These FORMS ARE AVAILABLE IN ALTERNATIVE FORMAT AND THE FOLLOWING LANGUAGES:**

**[List, in other languages and formats (TTY, Braille, and other services) that this is an important form and the person should ask for a translated copy]**

REQUEST FOR REASONABLE ACCOMMODATION/MODIFICATION AND  
AUTHORIZATION FOR RELEASE OF INFORMATION

To: People who use or apply to use PHA housing or services who are disabled.

If you are disabled and would like to ask the PHA for an accommodation or modification of a housing unit to help with a disability, please fill out this form. It is not necessary that you use this form to make a reasonable accommodation request (for example, you could make a request in a letter or by email or just verbally), but the form may help the PHA understand your request and respond to it. The form has two pages. Use extra sheets of paper if you need more space.

PLEASE KEEP COPIES OF ALL DOCUMENTS YOU SUBMIT TO YOUR HOUSING PROVIDER

If you would like help with this form or with making your request, you may speak with \_\_\_\_\_.

When you are done, give the form to \_\_\_\_\_.

You can also send the form to:

Civil Rights Compliance Coordinator  
Public Housing Authority  
123 Main Street  
Anywhere, CA  
(123)456-7890  
Fax (098) 765-4321

The PHA may also need information from a health care provider or other persons who can explain or verify your needs. It is not the PHA's job to determine whether or not you have a disability, but the PHA may request verification from a medical provider or other person who is qualified to make that determination. For this purpose, this form asks you to list these persons and allow them to share some limited information with us (see attached form). You may also provide this verification directly to PHA.

If you have any questions or concerns, you may contact the PHA's Civil Rights Compliance Coordinator at the address or phone number listed above.

The PHA will respond to your request within ten working days from receiving it.

Thank you.

**Please be sure you have filled out both pages of this form. Page 1 of 2**

**Name of Person Who Needs the Accommodation:** \_\_\_\_\_

Address: \_\_\_\_\_ Unit \_\_\_\_\_

Daytime Phone#: \_\_\_\_\_

**Who Should we Contact about this Request (if other than person listed above):**

\_\_\_\_\_

Address: \_\_\_\_\_ Unit \_\_\_\_\_

Daytime Phone#: \_\_\_\_\_

**Requester Status**

Current PHA Tenant

Applicant for Tenancy

Applicant for Section 8 Voucher

Current Section 8 Voucher Holder

Other \_\_\_\_\_

**Request**

1. I am disabled (defined as having an impairment that limits one or more major life activities, or having a record of such an impairment).

2. I need the following change in a rule, policy, practice, or procedure because of my disability (if you need a physical change to your unit skip to the next question).

3. I need the following physical change to my apartment or other part of the housing development because of my disability

4a. I need this accommodation to help me use and enjoy my housing because (please remember that you don't have to disclose your disability):

**OR**

4b. My health care provider will confirm that there is a connection between my disability and this request. \_\_\_\_\_

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If PHA staff filled out this form as a written record of the request, using available information, did the staff person read it back to requester to make sure it is accurate (to be initialled by staff and requester)? Yes\_\_ No\_\_

Was this request made orally or in separate writing (circle one; attach writing)?

Yes \_\_\_ No \_\_\_

PHA Staff Signature \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_

**VERIFICATION**

I authorize the Public Housing Authority to verify, if necessary, that I have a disability and have the need for the reasonable accommodation I have requested. In order to verify this information the PHA may contact the following physician, psychiatrist, licensed psychologist, licensed nurse practitioner, licensed social worker, rehabilitation professional, or non-medical service agency whose function is to provide services to the disabled, or other expert in the field of \_\_\_\_\_. This release is limited to the information necessary to verify my request. This permission is good for ninety (90) days from the date I sign this. I can also withdraw this permission at any time. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

**Type of Information to be Disclosed:**

This authorization permits the above provider to disclose the following medical records:

All of the my health information that the provider has in his or her possession, including information relating to any medical history, physical condition and any treatment received by me.

*Signature and Date:* \_\_\_\_\_

All of my health information described above except the following:

\_\_\_\_\_

*Signature and Date:* \_\_\_\_\_

Only the following records or types of health information (include dates of treatment, types of treatment, or other designation):

\_\_\_\_\_

\_\_\_\_\_

*Signature and Date:* \_\_\_\_\_

Mental health records

Signature and Date: \_\_\_\_\_

Outpatient psychotherapy notes

Signature and Date: \_\_\_\_\_

**Duration:** This request shall become effective immediately and shall remain in effect until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**Revocation:** *I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to authorization.*

**Redisclosure:** I understand that once my health care provider discloses my information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Additional Copy:** I understand that I have a right to receive a copy of this authorization for my records. Copies of this release should be treated the same as an original.

Name of Provider: \_\_\_\_\_

Title of professional or expert: \_\_\_\_\_

Agency/Clinic/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

**I understand that the information obtained by the PHA will be kept completely confidential and used solely to make a determination on my reasonable accommodation request.**

**Please return this form as promptly as possible so that the PHA may make a determination on this request.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**For Translator:** I have translated this document for \_\_\_\_\_  
(individual authorizing release) in \_\_\_\_\_ (language)

Signature of Translator \_\_\_\_\_

Date \_\_\_\_\_

The area has a few other agencies that may help you make your request or help you if you are not satisfied with the PHA's response. Their names, addresses and phone numbers are listed on the attached piece of paper. Their services are free. PHA will gladly work with them or any other representative you may choose.