HOUSING AUTHORITIES
CITY OF EUREKA & COUNTY OF HUMBOLDT

735 WEST EVERDING STREET, EUREKA CA 95503
PHONE: (707) 443-4583 FAX: (707) 443-4762 TTY: (800) 651-5111

Client request for reasonable accommodation

NOTE: Applicant/Participant, please complete this form making sure to sign and date. The Head of Household AND the person requesting the accommodation, if 18 years of age or older. This form along with the Authorization of Release of Information for Reasonable Accommodation can be returned to the Housing Authority office. To be treated as a request for a reasonable accommodation, the person to whom the request is made must be able to understand that the accommodation is sought by or on behalf of someone with a disability and that there is a disability related need (nexus) for the accommodation.

[ ] Applicant [ ] Participant
[ ] HCV [ ] PH/EFH [ ] EHV [ ] MSV [ ] ESH (CTCAC may have own form (they have for Live-In Aide)

PLEASE PRINT UNLESS OTHERWISE NOTED
Head of Household: _____
Physical Address: _____City: _____State: _____ Zip: _____
Mailing Address (if different): _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Cellular Phone: (_____) _____ Other: (_____) _____

Household Member Requesting Accommodation: _____
Last four digits of Social Security Number: XXX-XX-_____
Relationship to Head of Household (e.g. self, spouse, son, daughter): _____

Please complete the information below regarding the individual who needs the accommodation(s). It is important for you to provide as much detail as possible in order for the Housing Authorities of the City of Eureka and County of Humboldt (HACECH) to best evaluate this request. An additional bedroom may only be approved in rare circumstances. Please do not give medical history.

As a result of this disability, I am requesting the following reasonable accommodation(s) for the disabled household member listed above:

1. Describe the accommodation(s) you are requesting: _____
_____
_____

2. Describe why this accommodation is needed AND how it relates to the disability. Please do not tell us the extent of your disability or that of the individual seeking the accommodation: _____
_____
_____

Head of Household Signature: _____ Date: _____

Signature of person requesting accommodation: _____ Date: _____
If 18 years of age or older.

Signature of Witness, if applicable: _____ Date: _____
Must be 18 years of age or older

Thank you

The Housing Authorities are Equal Housing Opportunity Organizations

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Release of information for reasonable accommodation

This form must be completed and returned before a Reasonable Accommodation can be processed

[ ] Applicant [ ] Participant
[ ] HCV [ ] PH/EFH [ ] ESH

Name of Health Care Professional: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: (_____) _____ ext. _____ Fax Number: (_____) _____

Section 504 allows the Housing Authorities to obtain confirmation that the reasonable accommodation request is consistent with the patient/client's disability. To determine whether your request for accommodation is reasonable, we require a third party to complete the Verification of Need. This form is provided to your Health Care Professional. Therefore, your consent authorizing this information is necessary. The information obtained will be kept confidential and used solely for use in evaluating the reasonable accommodation request. This release must be delivered either by mail or in person to the Housing Authority.

Authorization to Release Information: By signing this form, you authorize your Health Care Professional to release the information requested on the Certification of Need and any subsequently clarification needed to verify the request for a reasonable accommodation. *(This form should be signed by the disabled member of the household requesting the reasonable accommodation or their legal Power of Attorney representative. Note: If the disabled member is a minor, the parent/guardian must sign on their behalf.)*

This permission is good for 6 months, (180) days from the date of signature/s. I also understand that I have the right to revoke this authorization at any time. Written request to revoke this authorization will be effective upon date received in office but will not apply to information that has already been sent for or been released in response to my request for a reasonable accommodation.

The Housing Authorities policy is to mail this Authorization for the Release of Information and the Verification of Need forms to your Health Care Professional. Hand delivered forms to and/or from your doctor may not be accepted as verification.

Printed Name of Head of Household: _____
Printed Name of Person Requesting Accommodation: _____
Date of Birth: _____ Last four digits of Social Security Number: XXX-XX-_____

Head of Household Signature: _____ Date: _____

Signature of person requesting accommodation: _____ Date: _____
If 18 years of age or older

Signature of Witness, if applicable: _____
Must be 18 years of age or older

Relationship to Head of Household: _____ Date: _____