SAN DIEGO HOUSING COMMISSION

Rental Assistance Division

REASONABLE ACCOMMODATION REQUEST FORM - EXCEPTION TO MOVE POLICY

All information requested on this form is required.

Head of Household Name : _____ Client ID # : _____

Address : _____ City, State & Zip : _____

SECTION 1: CLIENT'S REQUEST FOR REASONABLE ACCOMODATION AUTHORIZATION OF RELEASE OF INFORMATION

This request is for (family member): _____ Date of Birth: _____

The following exception to the Housing Commission's policy is being requested as a reasonable accommodation for the following reason/s:

To move prior to residing in the unit for the required twelve (12) month due to habitability issues that are exacerbating a health condition. Please specify the habitability issue/s and health condition that is being impacted:

_____

_____

_____

_____

Section 504 allows the Housing Commission to obtain confirmation that the reasonable accommodation request is consistent with the patient/client's disability as defined below. To determine whether your request for accommodation is reasonable, we require an impartial, knowledgeable professional to complete Section 3. Therefore your consent authorizing this information is necessary. This information will be held in confidence for use in evaluating the reasonable accommodation request.

By signing below, you authorize the physician/health care professional to release the specific information requested in Section 3 of this form to the San Diego Housing Commission to verify the request for a reasonable accommodation. *(This form should be signed by the disabled member of the household requesting the accommodation. Note: If the disabled member is a minor, the parent/guardian must sign on their behalf.)*

x_____ _____

Authorization to Release Information *Date*

Warning! Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction, punishable by fine not to exceed $250,000 and/or imprisonment of not more than 5 years.

Failure to provide all the applicable information will result in the disapproval of the request.

While most decisions are made in less time, we will make every effort to render a decision within sixty (60) calendar days.

If you have any questions, please call your Housing Assistant, _____ at 578-7777 ID# _____

SECTION 2: HUD DEFINITION OF DISABILITY

Section 504 of the Rehabilitation Act of 1973 and Fair Housing Amendments define a "disability" as:

- A physical or mental impairment that substantially limits one or more of the person's major life activities*
- A record of having such an impairment, or • Being regarded as having such impairment.

**Physical and mental impairments include physiological disorders or conditions, and mental or psychological disorders.*

SECTION 3: HEALTHCARE PROFESSIONAL'S CERTIFICATION OF NEED FOR ACCOMODATION

Dear Health Care Professional,

We ask that you carefully review this patient's request and verify, using your professional opinion, the existence of an impairment that substantiates the Reasonable Accommodation request. Requests will be considered on a case-by-case basis, as people with the same disability may not need or desire the same type of accommodation. To help the Housing Commission make an informed decision, **please write legibly**.

Head of Household: _____
HA #: _____

SECTION 3 - Continued: CERTIFICATION OF NEED FOR ACCOMODATION – EXCEPTION TO MOVE POLICY

Please note that such accommodations must be necessary as a result of the person's disability as opposed to a change that merely benefits the individual. We ask that you give careful, reasoned thought to this matter as this affects the total number of families the housing agency can assist.

FOR HEALTH CARE PROFESSIONAL TO COMPLETE: *This is not a request for medical records or detailed information about the disability*. Please limit your remarks to describing functional limitation(s) and to confirming that the accommodation that is requested above is relevant to this client's need. Thank you.

Patient Name: _____ **Date of Birth:** _____

1. Does this individual have a disability, as defined in Section 504 of the Rehabilitation Act? (*see previous page*) ☐ Yes ☐ No
   - **If you answered "Yes", please answer questions 2-5. If you answered no, please sign and return this form.**
2. Please give us an idea of how long the need will last. ☐ Temporary (*12 months or less*) ☐ Permanent *(Life Long)* ☐ Other _____
3. The following are **Major Life Activities** as defined in Section 504 of the Rehabilitation Act. Please check all the activities that are affected by the patient's diagnosed impairment and are connected to the accommodation request.

☐ Self Care	☐ Manual Tasks	☐ Walking	☐ Vision	☐ Hearing
☐ Speaking	☐ Breathing	☐ Learning	☐ Working	☐ Other: _____

4. Please describe how moving without a 30-day notice to the Housing Commission will assist your patient/client with the limitation/s posed by the disability, removing barriers to housing and allowing him/her to fully access and utilize the program *(please print):*

_____
_____
_____
_____

5. If the accommodation cannot be provided, please list all alternatives that would serve to make the Section 8 Program accessible *(please print):* _____

_____
_____
_____

I certify that it is my professional opinion that the above-named individual has a qualified disability that has a direct and verifiable need for accommodation to the Section 8 program. I understand that I could be called to testify regarding the validity of the information provided in this form. I further certify my professional opinion is in compliance with all applicable laws, regulations, standard industry practices and licensing guidelines.

Professional's Name: _____ Professional's License No.: _____

Address: _____

Phone Number: _____ Fax Number: _____

Professional's Signature: _____ *Date:* _____

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