REQUEST FOR REASONABLE ACCOMMODATION

Name of Applicant/Participant _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

1. Please indicate the name of the **disabled household member** who is requesting the accommodation

   _____

2. Please describe the accommodation you are requesting.

   _____

   _____

   _____

   _____

3. Please explain the reason you are requesting this accommodation and how it will provide you with equal opportunity to enjoy our housing programs, your rental unit and/or common areas.

   _____

   _____

   _____

   _____

4. Please have your doctor, health care provider or other qualified individual verify that your request is (1) related to your disability; (2) would provide you with an equal opportunity to enjoy our housing programs, or (3) that your disability restricts you from performing this task. (For your convenience, a medical provider verification form has been printed on the back of this request form.)

If you need assistance with this form or have any additional questions please contact us at (360) 423-0140. Please return this form to:

Housing Opportunities of SW Washington
820 11th Ave.
Longview WA 98632

Fax: (360) 425-9930
Toll Free Fax (888) 424-7145

EQUAL HOUSING OPPORTUNITY

REASONABLE ACCOMMODATION VERIFICATION

To: Qualified Individual (e.g., counselor, social worker, doctor, rehabilitation center, service agencies, self-help group, clinics or other entity identified by the person requesting a reasonable accommodation)

Applicant/Participant: _____ requested that Housing Opportunities of SW Washington provide the following reasonable accommodation(s):

_____

_____

_____

The Housing Authority is required by law to provide reasonable accommodations to disabled applicants/participants that will provide them with **equal opportunity to use and enjoy our housing programs, their rental unit and/or common areas**. Housing Opportunities of SW Washington does not provide reasonable accommodations when the request is a matter of convenience or preference only.

Please verify that the requested accommodation **(1) is related to the applicant or participant's disability; and (2) would provide the applicant/participant with an equal opportunity to enjoy our housing programs or (3) the applicant/participant's disability restricts them from performing this task.**

I, _____ **do / do not** (please circle one) believe the requested accommodation (1) is related to the applicant or participant's disability; (2) would provide the applicant or participant with an equal opportunity to enjoy our housing programs or (3) the applicant or participant's disability restricts them from performing this task.

Signature Date

Printed Name Phone Number

Professional Title

Address

NOTE: 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.

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