FALL RIVER HOUSING AUTHORITY

220 Johnson St. | P.O. Box 989 | Fall River, MA 02720

REQUEST FOR A REASONABLE ACCOMMODATION: HCVP PARTICIPANT

Name of Applicant/Head of Household: _____

Address: _____ **Phone:** _____

A **disability** is defined as *a physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment.*

1. The following member of my household has a disability as defined above:

   Name: _____ Relationship to Head: _____

2. As a result of his/her/my disability I request the following changes so that the person listed can live here as easily or successfully as the other residents. (Check the change(s) you need):

☐ A change in how we talk with you or give you information. Please write the particular support you need to enable us to communicate more effectively with you: _____

_____

☐ A regular apartment that has some things changed so I can use it. Please describe what needs to be changed:_____

_____

☐ A change in rule, services, or policy. Write what you need below:_____

_____

☐ Any other housing need you have because of a disability. Please write what you need below:

_____

Please note: As an HCVP participant modifications to your unit such as grab bars, a parking spot, an assistance animal, any modifications for the visually or hearing impaired, are to be agreed upon between yourself and your landlord. The FRHA fully supports and encourages landlords to make reasonable accommodations.

Signature: _____ Date: _____

Applicant/Tenant

Signature: _____ Date Received: _____

RA Coordinator

The following person is responsible for coordinating compliance with applicable non-discrimination requirements for the Fall River Housing Authority;

Name: Sarah St. Pierre, Esq., Compliance Officer

Phone: 508-679-0207

Fax: 508-675-4583

E-mail: sarah.st.pierre@fallriverha.org.

The Fall River Housing Authority does not discriminate on the basis of race, color, religion, sex, national origin, ancestry, sexual orientation, age, familial status, veteran status, public assistance, genetic information, gender identity, disability, or any other class protected by state or local law, in the access to its programs for employment, or in its activities, functions or services.

FALL RIVER HOUSING AUTHORITY
P.O. Box 989
Fall River, Massachusetts 02723

Telephone: 508-679-0207
Fax: 508-675-4583

GENERAL RELEASE OF INFORMATION

I, do hereby authorize, the Fall River Housing Authority, Leased Housing Department, or any person/agent associated with the Fall River Housing Authority, to have complete access to any and all record, files, documents, or other material which you have in your possession regarding me. I further authorize you to have copies made of all such material, if requested, and forward such copies of any and all records, files, documents, etc. to the Fall River Housing Authority, Leased Housing Department or any other person/agent associated with the Fall River Housing Authority. Finally, I authorize you to fully communicate verbally and/or in writing with the Fall River Housing Authority in any and all matters relating to me. By my execution of this General Release of Information, I fully authorize HUD, or the Fall River Housing Authority, Leased Housing Department, or any person/agent associated with the Fall River Housing Authority to request and obtain income information for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs.

_____
Printed Name

_____ _____
Signature Date

_____
D.O.B.

_____
Social Security Number

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PROVIDER'S VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION

Individual Requesting Accommodation: _____
(Tenant/Applicant Name)

Health Care or Service Provider: _____ _____
(Provider Name) *(Date)*

As the Fall River Housing Authority's **Reasonable Accommodation Coordinator**, the above-named individual has consented to our request to obtain verification from you of their **disability-related need for a reasonable accommodation.** Their signed authorization and reasonable accommodation request are attached for your review. Kindly respond to the questions below and return within five (5) business days. Please attached additional pages if needed. Thank you,

Sarah St. Pierre, Esq., Compliance Officer

Mail: Sarah St. Pierre, Esq. 220 Johnson St. Fall River, MA 02723
E-mail: sarah.st.pierre@fallriverha.org **Phone:** 508-679-0207 **Fax:** 508-675-4583

1) Please indicate <u>how current</u> your knowledge regarding the above-named individual:

- ☐ Within the last six (6) months
- ☐ Prior to the last six months
- ☐ Other _____

2) Briefly describe your qualifications with regard to providing services to disabled persons:

_____

_____

3) In your opinion, does the above-named individual have a qualified disability?*

- ☐ YES
- ☐ NO
- ☐ N/A (I have insufficient knowledge regarding this person or situation)

***Disability**: a physical or mental impairment that substantially limits one or more major life activities; a record of having such impairment; or being regarded as having such impairment.

4) Does the individual's impairment substantially limit one or more major life activities?

- ☐ YES (If yes, please describe below)
- ☐ NO

5) Does the impairment limit his/her ability to comply with the basic obligation of tenancy?

- ☐ YES (If yes please describe below)
- ☐ NO
- ☐ N/A

6) Would the accommodation requested by the resident (see attached request) control or alleviate the effects of such physical or mental impairment?

- ☐ YES (If yes please describe below)
- ☐ NO
- ☐ N/A

7) Are there alternative methods, procedures or devices that you can suggest to help control or alleviate the effects of such physical or mental impairment?

8) In your professional opinion, please respond to this request by checking the following:

- ☐ "I verify that the above-named individual, as a result of his/her disability, requires the requested reasonable accommodation in order to remove barriers to equal housing access."
- ☐ "I am **unable to verify** whether the above-named individual, as a result of his/her disability, requires the requested reasonable accommodation in order to remove barriers to equal housing access."
- ☐ "**I do not believe** that the above-named individual, as a result of his/her disability, requires the requested accommodation to remove barriers to equal housing access."

9) Provider certification and contact information. Please sign and date below.

Signature	Printed Name	Date
Title/Position	Email Address	Phone
Agency/Clinic Name (if applicable)	Address	City, State, Zip

Kindly complete, sign, and return this form within 5 business days. Feel free to fax back to Sarah St. Pierre, Esq. at 508-675-4583. Thank you.