



Housing Authority of the City of Alameda

701 Atlantic Avenue - Alameda, California 94501-2161 - TEL: (510) 747-4300 - FAX: (510) 522-7848 - TDD: (510) 522-8467

REQUEST FOR REASONABLE ACCOMMODATION

Instructions: This form may be used by clients or applicants to request a reasonable accommodation so that an individual with a disability may have equal opportunity to use and enjoy participation in any of the programs conducted by the Housing Authority of the City of Alameda.

Date of Request: _____

Name (Head of Household): _____

Address: _____

Phone: _____

1. The following household member has a disability as defined below:

- Head of Household
- Family Member (name): _____

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

2. Describe the accommodation/modification you are requesting:

- Extra Bedroom/Increase in Subsidy Standard
 - Live-in Aide to provide assistance with daily living activities
 - Medical Equipment
 - Separate sleeping room for: _____
- Special Communication Needs: _____

For Applicants or Participants under the Housing Choice Voucher Program or Project-Based Voucher Program ONLY:

- Voucher Extension
- Lease unit owned by relative
- Change in Payment Standard (only AFTER a specific unit is found with special features)
- Additional Utility Allowance (for medical equipment that uses extra electricity)

For Applicants or Tenants of Units Owned by the Housing Authority ONLY:

- Assistance Animal
- Live-in Aide to provide assistance with daily living activities (without an extra bedroom)
- Unit Modification, describe modification: _____
- Unit Transfer, description of needed feature: _____

Other, please describe: _____



PLEASE COMPLETE NEXT PAGE



3. Why is this accommodation needed? How does it relate to the disability of the above named family member? _____

4. Please provide the contact information of a knowledgeable professional who can verify the disability and the need for the accommodation requested.

_____	_____
Name	Title (Physician, Nurse, etc.)

Address	

_____	_____
Telephone Number	Fax Number

E-mail	

Name of Patient: _____	Medical Record Number _____
Address: _____	City/State/Zip: _____

Authorization to Release Information: I authorize the knowledgeable professional listed above to disclose relevant information to the Housing Authority of the City of Alameda regarding the need for a reasonable accommodation/modification for the above named family member. I understand that the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.

I understand that Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements or misrepresentations to any Department of Agency of the United States on any matter within its jurisdiction.

_____	_____
Signature of Head of Household	Date

Signature of above disabled family member, if 18 years or older	Date

Enclosure: Reasonable Accommodation Frequently Asked Questions