Housing
Authority of the City of Alameda

PHONE (510) 747-4300
RA FAX (844) 327-5415
TDD (510) 522-8367

701 Atlantic Avenue • Alameda, California 94501-2161

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):______________________ Phone: ______________

Address:____

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

☐Head of Household ☐Family Member (name): ______________________

Disability: A physical or mental impairment that 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: ____________________
☐ Other (please describe):____

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 OTHER SIDE

3. Explain why this accommodation is needed. Without stating the nature of the disability/diagnosis of the above named family member, please describe how this accommodation will grant equal access to the program or unit. ____

____

____

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