Request for a Reasonable Accommodation

| | Name: | | | |
|------|--|--|--|--|
| | Current Address: | | | |
| | Daytime Phone:Evening Phone: | | | |
| 1. | The following member of my household has a physical or mental condition, disorder or impairment that limits one (or more) major life activity and/or a record of physical or mental impairment and/or is perceived by another as an individual with a physical or mental impairment: | | | |
| | Name: | | | |
| 2. | As a result of his/her disability, the following change or changes is/are requested so that this household member can have an equal opportunity to enjoy a unit, a common area and any on-going services or activities offered on site. (Check the kind of change(s) you need.) | | | |
| | A change in my apartment or other part of the housing complex. This change is: | | | |
| | A change in the way we communicate with you or give you information. This change is: | | | |
| | A change in Management's rules, policies, practices, or services. This change is: | | | |
| | Other. This change is: | | | |
| 3. | You may verify that the person listed has a disability, the need for this request and possible alternatives to the specific request listed above by contacting the following medical/health provider: | | | |
| Na | me: | | | |
| | dress: | | | |
| Ph | one: | | | |
| FA | X: | | | |
| I (' | we) give you permission to contact the above individual for purposes of verifying that I (or a | | | |

family member) has a disability and needs the reasonable accommodation request above. I (we) understand that the information you obtain will be kept as confidential as reasonably possible while processing this request and used solely to respond to this request for an accommodation.

| Signed: | Date: |
|--------------|-------|
| Received by: | Date: |

11/11 (187)

Certification of Need for Reasonable Accommodation

| To: Physicians Name: Address: Phone: Fax: RE: | | | | |
|--|---|--|--|--|
| RE:Applicant/Tenant Soci | al Security Number | Apt # / Application # | | |
| THIS SECTION TO BE COMPLE | CTED BY APPLICANT/I | RESIDENT | | |
| RELEASE: I hereby authorize the release of the the release is voluntary and that the information will be kept confidential. | | | | |
| Signed: | Date | Date: | | |
| THIS SECTION TO BE COMPLETED BY P | HYSICIAN OR HEALT | H CARE PROVIDER | | |
| 1. In my opinion, the Applicant or Tenant has a disa | bility. 🗌 YES | □ NO | | |
| DEFENITION OF DISABLED: Under applicable I or mental condition, disorder or impairment that lim performing manual tasks, participating in social activ learning and working, and includes, but is not limite epilepsy, muscular dystrophy, multiple sclerosis, car Infection, mental retardation, and emotional illness. 2. In my opinion, the resident/applicant requires what order to use or enjoy his or her apartment or related a | its a major life activity suc vities, walking, seeing, hea d to, conditions such as cen neer, heart disease, Human at he or she has requested o | h as caring for one's self, ring, speaking, breathing, rebral palsy, autism, Immunodeficiency Virus | | |
| 3. Please describe any other accommodations or modification that could meet the residents/applicants needs in place of what is being requested. For example, if there is a less intrusive or less expansive way to provide the resident/applicant with equal access to housing despite his or her disability, please detail it: | | | | |
| Signature: | | | | |
| Name and Title of Physician or Professional | Tele | phone Number | | |