REQUEST FOR A REASONABLE ACCOMMODATION

Please Print Clearly using DARK ink. No Pastels or light colored inks.

Head of Household Name: ________________________________

1. The following household member, ______________________, is requesting a reasonable accommodation for their disability.
2. Describe the accommodation you are requesting (tell us specifically what you need):

3. Describe why this accommodation is needed and how it relates to a disability, **without** stating what your disability is:

4. If you are asking for an extension of time to search for housing, were you issued a Disabled and Medically Vulnerable (DMV) voucher through the 180/220 program or the Housing Services Center (HSC)? ____ Yes ____ No____ Unknown
5. Do you have a local advocate/caseworker: ____ YES ____ NO
6. What is that person's name: ______________________________________
7. What is their phone number: ________________________________

8. List the name of the health care provider or social worker who can verify the disability and the need for the accommodation requested. Return this form to the Housing Authority. The Housing Authority may contact this person directly for verification. **If you include contact information that is incomplete or incorrect, this form will be returned to you to complete and/or correct, which will delay the processing of your request.**

Name: ____________________________________ Name of Hospital, Clinic, or Office:____________________

Complete, current and accurate mailing address of the person you are asking us to contact:___________________

____

City: _____________________________ State: __________________ Zip Code: ________________

Phone: _________________________ Fax: ___________________________

You will be informed of the Housing Authority's granting, denial, or status of this request within thirty (30) days of the receipt of this request.

Authorization to Release Information**: I authorize the health care provider or social worker listed above to disclose relevant information to the Housing Authority of the County of Santa Cruz regarding the need for a reasonable accommodation. I understand the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.**

_____________________________ _____________________________ ____________________

Signature of Family Member requesting accommodation | Printed Name | Date

Please complete and return this form at your earliest convenience. If you have any questions regarding the completion of this form, please call our offices at (831) 454-5955 Monday through Thursday, between 8:00 AM - 4:45 PM and Friday from 8:00 AM to 12:00 PM. Fax to 831-469-3712

This section for Administrative purposes only
Authorizing
Person's
Initials: