HOUSING CHOICE VOUCHER SECTION 8
FAMILY REQUEST FOR REASONABLE ACCOMODATIONS

WINDSOR LOCKS HOUSING AUTHORITY
120 SOUTHWEST AVENUE
WINDSOR LOCKS, CT. 06096
(860)-627-1455

HOUSING CHOICE VOUCHER (SECTION 8)
Family Request for Reasonable Accommodation
(THIS FORM IS AVAILABLE IN LARGER FONT OR ALTERNATIVE FORMAT UPON REQUEST)
PLEASE PRINT CLEARLY

Head of Household: _____ Phone: _____

Address: _____ State/Zip:_____

Email Address: _____

Currently, I am:
☐ An applicant on the waiting list for the Housing Choice Voucher (Section 8) program
☐ A participant in the Housing Choice Voucher (Section 8) program1

Household member who needs accommodation: _____

The household member above has a disability because they have a physical, mental or emotional impairment that limits one or more life activities or has a record of having such an impairment.

Please fill out all the following information regarding the person who needs the accommodation(s). Please DO NOT submit medical records or provide confidential medical information regarding the nature or extent of the disability.

As a result of this disability, I am requesting the following reasonable accommodation(s) from the housing authority for the disabled household member listed above. Please answer the questions below.

☐ The household member needs a live-in aide. A daily in-home worker, housekeeper, or rotating shifts are not equally effective as a reasonable accommodation

☐ Extra bedroom for medical equipment. ((note: if necessary, a PHA inspector may view the equipment to confirm that all sleeping and living spaces are not adequate as an accommodation)

☐ The household member needs a change in a rule, policy or procedure. (Note that fundamental requirements must still be met). Please specify the necessary change.1

☐ Other (for example, a change in the way the housing authority communicates with you). Please specify the necessary change. Provide additional pages if necessary.

I understand that the information obtained by the housing authority will be kept completely confidential and used solely to make a determination on my reasonable accommodation request.

FRAUD AND FALSE STATEMENTS

Title 18, Section 1001 of the U.S. Code states that a person who knowingly and willingly makes false and fraudulent statements to any department of the United States Government, including the Department of Housing and Urban Development (HUD), a public housing authority (PHA), and any owner (or employee of HUD, the PHA, or the owner) may be subject to penalties that include fines and/or imprisonment.

I certify by signing below that all the information provided above is true, accurate and complete to the best of my knowledge.

_____ _____
Signature Date

For PHA Use ONLY: PHA Certification

☐ I certify that this individual's disability is obvious or otherwise known to the PHA and no further verification is required.

☐ I certify that this individual's need for the accommodation is readily apparent or known to the PHA and no further verification is required.

_____ _____
Signature of PHA Official Date

_____ _____
Approval of PHA 504 Coordinator Dat2e

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AUTHORIZATION

I/we authorize the Housing Authority (PHA) to verify that the above-referenced household member has a disability and that the accommodation(s) requested is necessary in order to remove or alleviate barriers to housing. To verify this information, the housing authority may contact the below-named professional who is knowledgeable about my situation and competent to render a professional opinion. I understand the information the housing authority obtains will be kept completely confidential and used solely to evaluate the request.

This authorization is requested because third-party verification may be needed.

Name of Professional: _____

Field of Practice: _____ Agency/Clinic/Facility: _____

Email: _____ Phone: ( ) _____

Address: _____

_____ _____
X Signature of Head of Household or authorized Guardian ** Date

**** If the family member needing the accommodation(s) is under 18 years of age, are you the parent or guardian of the household member?** ☐ **Yes** ☐ **No**

X_____ _____
Signature of family member needing the accommodation (only if 18 years of age or older) Date

Please return this form as promptly as possible so that the housing authority may make a determination on this request.

_____ _____
PHA Representative Date

_____ _____
Phone Email

HOUSING CHOICE VOUCHER SECTION 8
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Windsor Locks Housing Authority
VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION
HOUSING CHOICE VOUCHER (Section 8) PROGRAM
Please do not send or attach medical records

Individual Requesting Accommodation _____

Name of PHA Head of Household: _____

Dear Knowledgeable Professional:

Please read this form completely – the information provided here is very important. The individual listed above has identified him or herself as being disabled under the Fair Housing Act and has asked for an accommodation from the (PHA) to meet housing-related needs necessary in order to remove, alleviate, or mitigate barriers to their housing or housing programs due to their disability-related limitations.

You have been authorized to release information to us regarding the individual's need for an accommodation. That authorization is attached.

PHA grants reasonable accommodation requests based, if necessary, on verification of need from a professional who is knowledgeable about the individual's situation and competent to render an opinion. Such verification may be from a physician, other medical or non-medical service agency professional, or other knowledgeable professional. Verification could include but not be limited to:

- Verification that the person is a qualifying person with disabilities.
- Verification that there is a direct relationship ("nexus") between the nature of the person's disabilities and the accommodation requested.
- Verification that the accommodation is necessary for the person to have equal opportunity to participate in or access the PHA's programs and services.

Please complete and return this form to the PHA. **Confidential medical records will not be accepted**.

If you are not able to verify the information requested in this form, the PHA will notify the family and they may request verification from another professional or licensed practitioner.

If you have any questions, or would like further information, please feel free to contact

_____

(860) -643-2163 ext.

_____@wlocks.com

HOUSING CHOICE VOUCHER SECTION 8
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Section I – Verification of Disability

☐ It is NOT necessary for you to fill out this Section. Please proceed to Section II.

☐ Please complete this Section before proceeding to Section II.

An "individual with a disability" is any person who has a physical, mental or emotional impairment that limits one or more life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction and alcoholism. The definition of an "individual with a disability" does not include a person whose current use of alcohol or drugs is the barrier that prevents the person from participating in PHA's housing program and services. (A more detailed definition is provided in the Code of Federal Regulations at 24 CFR 8.3, which PHA staff would be glad to provide to you.)

Does the person named above qualify as an "individual with a disability," according to this definition?

☐ Yes ☐ No ☐ Unable to verify Initials _____

Section II – Verification of Need for Requested Accommodation **Please do not include medical records**	
I am knowledgeable about this individual's situation.	☐ Yes ☐ No

In my professional assessment of the disabled individual's needs, I certify that:

☐ The disabled individual requires a live-in aide. A daily in-home worker or rotating shifts are not adequate to provide an opportunity equal to that afforded others.

☐ The disabled individual requires an extra bedroom for medical equipment (note: if necessary, a PHA inspector may view the equipment to confirm that all sleeping and living spaces are not adequate as an accommodation)

☐ The disabled individual requires a change in a policy or procedure as a direct result of his/her disability in order to be afforded an equal housing opportunity. Please explain what change in policy or procedure is being requested.

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CERTIFICATION

Based on your professional opinion and assessment of needs, please check only one of the following:

☐ I certify that the enclosed request for an accommodation is necessary for the disabled household member, as a result of their disability-related limitations, in order to have an equal housing opportunity.

OR

☐ I cannot certify that the enclosed request is necessary for the disabled household member, as a result of their disability-related limitations, in order to have an equal housing opportunity.

Please certify below:

☐ This certification is true and accurate to the best of my professional judgment.

_____ _____
Professional's Signature Date

_____ _____
Name (Please print clearly) Title of professional

_____
Agency or Clinic, if applicable

_____
Complete Address

( ) _____ ( ) _____ _____
Phone Fax Email

Please return form to: [WLHA] as soon as possible.

ATTN: _____

Title: _____

Address:_____

( ) _____ ( )_____ _____
Phone Fax Email