

RIGHT OF REASONABLE ACCOMMODATION NOTICE TO APPLICANT/TENANT (Applicant/Tenant Copy of Rights)

In accordance with State and Federal Fair Housing laws, the Housing Authority of Maricopa County (HAMC) does not discriminate against any person due to disability. Upon request, HAMC provides auxiliary aids and services as well as reasonable accommodations that allow people with disabilities an equal opportunity to participate in and benefit from the HAMC housing programs. However, services requested less than 48 hours in advance may not be able to be provided.

A reasonable accommodation is a modification or change to: 1) the owner's or the HAMC's policies and procedures; or 2) a property owner's unit that would assist an otherwise eligible family with a member with a disability to fully participate in the Section 8 Program. Owners are legally obligated to permit reasonable accommodations.

If you or any member of your family has a disability, you may request a reasonable accommodation at any time during the application process or after admission to the program. If you do request an accommodation, you are not required to disclose the exact nature of your disability to HAMC or to the owner/landlord of the property. Examples of accommodations you may request from HAMC include, but are not limited to:

- Arranging home visits for disable persons unable to come into the HAMC office for appointments.
- Issuing assistance for an additional bedroom to accommodate special needs such as a live-in aide or for bulky medical equipment.
- Extending a voucher term if the participant has difficulty locating a unit due to a disability.
- Allowing a reasonable extension of time so that a person with disabilities can complete program requirements.
- Making an exception to Fair Market Rents or Voucher Payment Standards as allowed under HUD regulations.
- Making an exception to the "renting to relatives" rule (except where Federal Law prohibits).

A rental unit may be physically modified at the participant's expense with permission of the owner/landlord. The owner/landlord may ask for verification that the requested modifications are necessary for a disabled family member to live in the unit. The owner may also require the renter to restore the premises to its original condition (reasonable wear and tear excepted) when the participant moves out and may collect a deposit to ensure that the restoration can be made.

Examples of accommodations that may be permitted with owner's prior approval at participant's expense, include, but are not limited to:

- Installation of grab bars, handrails, or level handles instead of "doorknobs".
- Modifying a unit to be wheelchair accessible. The client may also choose to move to a unit with existing built-in handicap accessible features.
- Allowing a qualified disabled family member to have a Service Animal where a "no pet" policy exists.
- Allowing an outside agency to assist a disabled client to meet the owner's lease agreement.

An applicant or participant family with a disabled member must be able to meet the essential obligations of both the Section 8 Housing Choice Voucher Program and the lease agreement with the owner/landlord. An applicant or participant may meet their obligations independently or with assistance from another person or agency.

TO EXPEDITE THE REASONABLE ACCOMMODATION PROCESS, PLEASE ATTACH A SIGNED HIPPA RELEASE THAT INCLUDES YOUR MEDICAL PROVIDER'S INFORMATION WITH THIS FORM. OTHERWISE, THE VERIFICATION PROCESS MAY TAKE UP TO 30 DAYS.



REASONABLE ACCOMMODATION REQUEST

YOU MUST PROVIDE MEDICAL PROVIDER'S STATEMENT WITH FORMS.

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

Part I - To be completed by Head of Household (check one only):

I **AM NOT** requesting a Reasonable Accommodation. *(Do not complete remainder of packet.)*

Signature: _____ Date: _____

I **AM** requesting a Reasonable Accommodation for myself, or another person listed on my household composition, due to disability as defined above. *(Continue to Part II)*

Part II - To be completed by Head of Household:

Head of Household Name: _____ SSN: _____

Address: _____ Phone: _____

Name of Disabled Member (if different from above): _____ DOB: _____

A. To request a Reasonable Accommodation related to a specific unit, check all that apply. (Continue to Part III of this packet.):

- An extra bedroom for a 24-hour a day live-in aide *(additional documentation required)*
- A separate bedroom for medical equipment *(size of equipment may not warrant a separate bedroom)*
- A separate bedroom for the person with a disability
- Approval to remain in your current unit or move to a unit due to your disability *(other requirements may apply)*
- Approval to rent a unit owned by a relative who helps with your daily living needs
- Other (explain): _____

B. To request a Reasonable Accommodation if asked to come to the housing authority office, please check all that apply. (DO NOT complete remainder of packet):

- Space to accommodate a Service Animal
- Accommodations for a wheelchair
- A home visit (because you are too ill/disabled to come to the office)
- An interpreter for: [] Sign Language [] Spanish/English Interpreter [] Other Language Interpreter (specify language): _____
- A reader to read documents for you
- Other (explain): _____



Part III - To be completed by Head of Household:

Please complete the remainder of this form. Use a separate sheet of paper, if necessary. You are not required to state the exact nature of the disability.

Head of Household Name: _____ SS#: _____

Address: _____ Phone: _____

A. _____ (Name of disabled Household Member),
has a disability defined as a physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment.

B. Describe the accommodation you are requesting:

C. Describe why this accommodation is needed and how it is related to the disability:

D. List the name of the Medical Provider or Agency providing professional services that relate to the disability that can verify the disability and the need for the accommodation requested.

Name: _____ Position/Title: _____

Mailing Address: _____

Phone: _____ FAX: _____

*Under penalty of perjury, I certify by my signature below that the information contained in this document is true and accurate. I further understand that under Title 18, Section 1001, of the United States Code that a person is guilty of a felony for knowingly and willfully making false, inaccurate, or fraudulent statements to any department or agency of the United States government, including the Housing Authority of Maricopa County. I also understand that verification will be mailed to the Medical Provider I have listed above, and the same Medical Provider will be asked to certify, under penalty of perjury, that the reasonable accommodation is necessary. If the Medical Provider **does not** certify the necessity of the reasonable accommodation, I understand the housing authority will **not** approve the Reasonable Accommodation Request. I also understand that if the Reasonable Accommodation is approved, I will not hold the housing authority liable in any manner or means related to the Reasonable Accommodation.*

Head of Household Signature

Date

