

**REQUEST FOR A REASONABLE ACCOMMODATION  
 DUE TO A DISABILITY – SECTION 8**

**To be completed by the Resident:**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

1. The following member of my household has a disability: \_\_\_\_\_  
Disability is defined as: A physical or mental impairment that substantially limits one or more major life activities: a record of having such an impairment, or regarded as having such an impairment.
2. What is your accommodation request? \_\_\_\_\_  
 \_\_\_\_\_
3. How does this Accommodation request allow you full participation of our housing program? \_\_\_\_\_  
 \_\_\_\_\_

I understand that I must still abide by the current signed lease, and that my accommodation request is only to ask for an exception to a part of the lease, and that is contingent on a one time or a permanent basis as decided by the Accommodation Team.

\_\_\_\_\_  
 Head of Household Signature Date

\*\*\*\*\*

**To be completed by a Qualified Medical Professional:**

By signing this request, I am verifying that the resident specified in line 1 (above) meets the definition of disability defined as “a physical or mental impairment which substantially limits one or more major life activities: a record of such impairment; or being regarded as having such impairment. This term does not include current or illegal use of or addictions of a controlled substance”. Major life activity is defined as: function such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.”

1. Please verify the medical need for the reasonable accommodation: \_\_\_\_\_  
 \_\_\_\_\_
2. Explain in detail the requested accommodation and how it relates to the disability: \_\_\_\_\_  
 \_\_\_\_\_
3. Please describe the impact to the participant’s disability without the accommodation.  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Please identify how long you have treated or provided services to this person, and also indicate if your relationship with this person is of an on-going nature. \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE OF MEDICAL PROFESSIONAL PHONE

\_\_\_\_\_  
 PRINT NAME OF MEDICAL PROFESSIONAL DATE

*(NOTE: Such changes must NOT be just something the person desires, but rather, they MUST be changes that are necessary for the person to have equal access and enjoyment of the housing and its programs. By signing, you are indicating that you believe the accommodation is NECESSARY and will achieve its stated purpose.)*

