Bellingham & Whatcom County Housing Authorities

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Request for Reasonable Accommodation

Date: _____

Head of Household:	Health Care Provider Name and Address:
Address:	Health Care Provider Phone, Fax, Email:
Current Status: ☐ Applicant ☐ Participant/Tenant	

Section 504 of the Rehabilitation Act of 1973, as amended, defines individuals with disabilities as any person who: Has a physical or mental impairment that limits "Major life activities" - functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working; Has a "record of such an impairment" - a history of, a mental or physical impairment that substantially limits one or more major life activities; "Is regarded as having an impairment" - is treated by a medical/health care professional for such impairment.

1. Are you, or any family member disabled as defined above?
   If No – Stop Here. You may not request a reasonable accommodation.
   If Yes – Complete the remaining questions.

2. Name of family member that meets definition of disabled: _____

3. Relationship to Head of Household: _____

4. Accommodation Requested (Check the appropriate accommodation from the options below):

Requested accommodation or modification must be necessary for a person with a disability to have equal opportunity to use and enjoy a dwelling, including public and common use spaces.

☐ Structural Modification ☐ ADA Unit ☐ Live-in Aide ☐ Separate Bedroom ☐ Shared Housing/Rent from Relative
☐ Service/Companion Animal ☐ Voucher Extension ☐ Payment Standard Exception
☐ Other: _____

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5. What is the connection between the accommodation requested and the person's disability?

_____

_____

_____

_____

I hereby authorize the above-named Health Care Provider to complete the Reasonable Accommodation Verification and disclose to BWCHA and its authorized representatives the following information related to my health care: medical and mental health information concerning whether I have a disability and whether the accommodation I have requested is medically necessary to accommodate my disability by making housing and housing services accessible for me. I also authorize the health care provider to discuss with BWCHA and its representative's alternative forms of accommodation which might be used to achieve the needed accessibility result. The health care provider is authorized to disclose any and all health care information which would otherwise be held as confidential in order to assist the Housing Authority in determining whether the accommodation I have requested is necessary and/or whether an alternative accommodation would achieve the same result.

This authorization is valid for twelve (12) months after the date of my signed release. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken based on the original authorization.

Signature _____ Date _____

Approvals and notification (check approved/denied, sign and date)

❑ Approved ❑ Denied by HCI/HCII: _____ Date: _____

❑ Approved ❑ Denied by HCIII: _____ Date: _____

❑ Approved ❑ Denied by Supervisor: _____ Date: _____

❑ Forwarded to Maintenance for work order: _____ Date: _____

If denied, reason for denial: _____

Notice sent to client by: _____ Date: _____

Accommodation completed and updated in tracker: _____ Date: _____