Housing Authority of the City and County of San Francisco
Reasonable Accommodation Request

Notice of Right to Reasonable Accommodation

(Confidential Information. This information will not be disclosed or released, except as permitted by law.)

If you are a person with a disability and you need:

- A change in the rules or policies or how we do things that would make it easier for you to receive rental assistance, and live or use our facilities, or take part in programs on site;
- A repair or change in your apartment or special type of apartment that would make it easier for you to live here and use the facilities or take part in our programs on site;
- A repair or change to some other part of the housing site that would make it easier for you to live here and use the facilities or take part in our programs on site; or
- A change in the way we communicate with you or give you information, for example appropriate auxiliary aids, Telecommunications Devices for the Deaf-TDD, qualified sign language interpreters for persons with speech or hearing impairments, or alternate format for vision impairment.

You can ask for this change, which is called a reasonable accommodation.

If you can show that you have a disability and if your request is reasonable, not too expensive, and not too difficult to arrange, we will try to make the changes you request.

We will make a decision as soon as possible, at least within thirty (30) days, unless you agree to an extension of time. We will let you know if we need more information or verification forms from you or if we would like to discuss other ways of meeting your needs. If we turn down your request, we will explain the reasons, and you can give us additional information if you think that will help.

If you need help in filling out a Reasonable Accommodation Request Form, or if you want to give us your request in some other way, we will help you. There is a **Reasonable Accommodation Request Form** on the other side of this notice. You may request a Reasonable Accommodation Request Form at any time you wish to request a reasonable accommodation.

Along with the Request Form, please also submit a third-party verification of your disability, such as the attached **Care Provider Verification Form**, a letter from or the contact information of a doctor, other medical professional, non-medical service agency, or another reliable third-party who is in a position to know about your disability.

Reasonable Accommodation Request Form

____
Date of Request

____
Name of Resident or Applicant Telephone

____
Address

1. The following household member,______________________________________, has a disability as defined below:

A physical or mental impairment that limits one or more of the person's major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working); and has a record of having, or being perceived as having, a physical or mental impairment. It does not include current illegal use of, or addiction to, a controlled substance

2. Reasonable accommodation requested:
(*Example: Live-in aide, additional bedroom/increase in subsidy*).

____
____
____

3. I need this reasonable accommodation because:

____
____
____

4. List the name of your doctor, health care provider or other qualified individual who can verify the request:

____
Name Title

____
Address

____
Phone Fax

By signing below, I hereby authorize the Authority and its staff to contact the individual or agency listed above to obtain any information or materials which are deemed necessary to make a determination regarding my request for Reasonable Accommodation. I hereby authorize the individual or agency listed above to cooperate fully and divulge all information requested.

____
Signature Date

Care Provider Verification Form

Along with the Request form, please also submit a third-party verification of your disability, such as this **Care Provider Verification Form**, a letter from or the contact information of a doctor, other medical professional, non-medical service agency, or another reliable third-party who is in a position to know about your disability.

____
Date

____
Patient Name   Client #

____
Name of Care Provider

____
Address

Dear Care Provider,

Enclosed is a form signed by ________________________________ asking you to verify their need for a reasonable accommodation in one of the Housing Authority of the City and County of San Francisco (Authority) programs.

State and Federal laws require housing providers to make reasonable accommodations or changes to either the apartments, other parts of the housing complex, or to change rules, policies, and procedures if such changes are necessary to enable a person with a disability to have equal access to and enjoyment of the apartment and other facilities or programs. Please note that such changes must be necessary for the person to have equal access and enjoyment of the housing and programs, not just desirable.

The applicant or tenant in question has requested the accommodation described on the enclosed form. Please indicate by answering the questions below whether you believe the accommodation is necessary and will achieve its stated purpose. You may also add other information that would be helpful in making the right accommodation for the person. This form should not be used to discuss the person's diagnosis or any other information that is not directly relevant to the request for an accommodation.

Please note that the applicant/tenant has signed the form requesting you to answer the questions. You can call customer care at (415) 715-5200 if you have any questions.

In order to maintain client confidentiality, we require this form be returned to the Authority by mail or fax at the number or addresses listed below. Please keep copies of all documents you submit to the Authority.

Section 504 of the Rehabilitation Act and the Fair Housing Amendments Act define a 'disability' as a physical or mental impairment which substantially limits one or more of a person's major life activities, a record of having such an impairment, or being regarded as having such an impairment.

1. Does this individual have a disability, as defined above? ☐ Yes ☐ No
2. If YES, does this individual, because of this disability, need the accommodation/modification requested? ☐ Yes ☐ No
3. If YES, please describe the accommodations/modifications needed:

____

____

____

Contact Information for Individual Completing Form

____
Name Position

____
Address

____
Phone Number

____
Signature Date

Please Note: Any person who signs this statement and who willingly states as true, any matter which they knows to be false, is subject to the penalties prescribed for Perjury in Section 118 of the California Penal Code and Section 11054 of the Welfare and Institutions Code.