MANCHESTER HOUSING AUTHORITY

24 Bluefield Drive Manchester, CT 06040-4702 860-643-2163 860-643-2999(fax) manchesterha.org

Joseph D'Ascoli Executive Director

THIS IS AN IMPORTANT NOTICE. PLEASE HAVE IT TRANSLATED.
Este es un aviso importante. Sírvase mandarlo traducir.
Questa é una notizia molto importante. Per piacere falla tradurre.
C'est important. Veuillez faire traduire.
Este é um aviso importante. Por favor mande traduzi-lo.
Es ê un avizu importanti. Di favor, manda traduzil.
Se yon anons ki enpòtan anpil. Sou Ple, fè tradwi li pou w.
Σπουδαιε Πληροφορεια – Παρακαλω να το μεταφρασετε
ĐÂY LÀ MỘT BẢN THÔNG CÁO QUAN TRỌNG.
XIN VUI LÒNG CHO DỊCH LẠI THÔNG CÁO NÀY

REQUEST FOR REASONABLE ACCOMMODATION

NOTE: This form is to be completed and signed by the Head of Household on behalf of the Household Member needing the accommodation. Please complete a separate "Request for Reasonable Accommodation" form for each Household Member requiring an accommodation(s).

If the disabled Household Member who needs the accommodation is 18 years of age or older, he or she AND the Head of Household must sign this form.

PLEASE PRINT CLEARLY

Head of Household: _____

Household Member Who Needs an Accommodation(s): _____

Address: _____

Daytime Tel: ( ) _____

Cell Phone: ( ) _____

MANCHESTER HOUSING AUTHORITY

24 Bluefield Drive Manchester, CT 06040-4702 860-643-2163 860-643-2999(fax) manchesterha.org

Joseph D'Ascoli Executive Director

Household Member Who Needs Accommodation(s): _____

Please fill out the information below regarding the individual who needs the accommodation(s). It is important for you to provide as much detail as possible in order for the MHA to best evaluate this request.

The following Household Member has a disability because: **He or she has a physical or mental impairment that substantially limits one or more life activities or has a record of having such an impairment.**

Name of Household Member: _____

Relationship to Head of Household (e.g. daughter, son, parent): _____

1. As a result of this disability, I am requesting the following reasonable accommodation(s) from the Manchester Housing Authority (MHA) for the disabled Household Member listed above (Please check one or more boxes below):

   ___ (a) Special unit features (b) physical modification to common areas, or (c) if a resident, a transfer to another unit that meets my needs. Please provide details. Attach additional pages if necessary.

   _____

   _____

   _____

   _____

   _____

   ___ A change in the following rule, policy or procedure. (Note that a change in how to meet the requirements of the lease may be requested, however, the lease's requirements must still be met.) Please specify the necessary change. Attach additional pages if necessary.

   _____

   _____

   _____

   _____

   _____

Please make sure that you have filled out all four pages of this form

Household Member Who Needs Accommodation(s): _____

___ Other (for example, a change in the way the MHA communicates with you). Please specify the necessary change. Attach additional pages if necessary.

_____

_____

_____

_____

_____

2. The disabled Household Member needs this reasonable accommodation(s) because (you may attach additional pages if necessary):

_____

_____

_____

_____

_____

3. To get to my appointments. I mostly rely on (please check off one):

___ My car ___ The bus ___ Walking ___ Other_____

4. If you have any additional information you wish to provide, you may use the space below or attach additional pages if necessary.

_____

_____

_____

_____

_____

Please make sure that you have filled out all four pages of this form

MANCHESTER HOUSING AUTHORITY

24 Bluefield Drive Manchester, CT 06040-4702 860-643-2163 860-643-2999(fax) manchesterha.org

Joseph D'Ascoli Executive Director

Household Member Who Needs Accommodation(s): _____

(continued from page 3)

AUTHORIZATION

I/We authorize the MHA to verify that the above-referenced Household Member, has a disability and we need the reasonable accommodation(s) requested. To verify this information, the MHA may contact the below-named physician, psychiatrist, licensed nurse practitioner, licensed social worker, rehabilitation professional or non-medical service agency whose function is to provide services to the disabled. (Note: This authorization is requested because third-party verification may be needed. Be advised that you may submit supporting documentation directly to the MHA rather than having the MHA contact your provider, in order to facilitate the evaluation of your request).

Name of Provider: _____ Field of Practice: _____

Agency/Clinic/Facility: _____

Address: _____

Telephone ( ) _____ Fax ( ) _____

I/We understand that the information obtained by the MHA will be kept completely confidential and used solely to make an evaluation and determination on this reasonable accommodation(s) request.

_____ _____, 20____

Signature of Head of Household or **Authorized Guardian Date

**** If the Household Member needing the accommodation(s) is under 18 years of age, are you the parent or guardian of Household Member needing accommodation?. ___Yes ___No**

_____ _____

Signature of Household Member needing the accommodation(s) (only if 18 years old or older) Date

_____ _____ _____

Signature of Witness Relationship to Head of Household Date

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

Please make sure that you have filled out all four pages of this form