Hernando County Housing Authority

621 W. Jefferson Street
Brooksville, FL 34601

RE: Request for Reasonable Accommodation Instructions

Dear Tenant/Applicant,
Let this serve as notification of the procedures for requesting a reasonable accommodation. In order for a reasonable accommodation request to be approved, two things must be verified: (1) the individual making the request must have a disability, and (2) there must be a connection between the disability and the requested accommodation.

The HCHA will review the reasonable accommodation request once the following forms are received:

- **Request for a Reasonable Accommodation** (Pages 2 & 3)
  This section must be completed by you. Please provide a brief explanation of what you are requesting. You (or your Power of Attorney) must sign the request form.

- **Certification of Need for Reasonable Accommodation & Third-Party Verification**(Pages 4 & 5)
  This section must be completed by a qualified medical, rehabilitation, or other knowledgeable third-party professional. The medical provider must sign the certification form.

IMPORTANT: This packet includes two separate sections.
One must be completed by the tenant, and one must be completed by a medical provider.

TENANT: Complete Pages 2 & 3 (front and back)
DOCTOR/MEDICAL PROFESSIONAL: Complete Pages 4 & 5 (front and back)

You are responsible for providing these forms to your medical provider and ensuring they are completed and returned promptly to avoid delays in processing your request.

Packets submitted incomplete or completed incorrectly will be returned and will delay processing. Failure to submit completed forms may result in denial of the request. If you have any questions, please contact our office at 352-754-4160.

Sincerely,
Kaitlyn Kamin and Debbie Coble, HCV Specialists
Hernando County Housing Authority

Hernando County Housing Authority
REQUEST FOR REASONABLE ACCOMMODATION
TENANT: YOU MUST COMPLETE PAGES 2 AND 3

This portion of the form is to be completed by the Applicant/Participant or on behalf of a family member and may be submitted to the Hernando County Housing Authority (HCHA) at any time. If you need assistance completing this form, or you have any additional questions or concerns, please contact your assigned case manager at 352-754-4160.

_____
Date of Request

_____ _____
Name of Head of Household *Phone Number*

_____ _____
Address *City, State, and Zip Code*

1. Participant needing the reasonable accommodation:
☐ Head of Household ☐ Family Member: _____
Name

2. What accommodation(s) are you requesting? (Please be specific)

☐ Extra bedroom necessary for a person with a disability. Please explain why the extra bedroom is needed.

_____

☐ Extra bedroom necessary for equipment. Please specify, in detail the type and size of the equipment.

_____

☐ Live-in Aide. The person with a disability requires a person to live in the unit with them to administer care. (*Please also request the "Live-In Aide" Form; that will need to be completed as well)*

_____

Name of proposed Live-in Aide: _____

☐ Special Communication needed for either persons with visual impairments or hearing impairments. Please specify in detail the type of communication that is needed:

_____

☐ Unit transfer. Please specify in detail the type of unit that is needed.

_____

☐ Lease a unit owned by a relative. Please describe why renting from a relative will assist you.

_____

☐ Other policy or rule change(s). Please explain: _____

_____

3. Reason for requesting this accommodation: _____

_____

(Please state why you need it and when you need it)

4. You will need to provide proof of your need for the accommodation. Information must be provided from your doctor or other medical professional, a peer support group, a non-medical service agency, or a reliable third party who is in a position to know about the person's disability.

5. The medical professional, a peer support group, a non-medical service agency, or reliable third party who is in a position to know about the person's disability who provides the information for the requested accommodation must either: complete the Certification of Need for Reasonable Accommodation and Third Party Verification or must prepare a letter that fully answers the medical questions that are included on the form and gives the doctor's medical opinion whether or not they believe that the requested accommodation is appropriate for you. Forms or letters that are incomplete will require the Housing Authority to ask for more information; this will delay the time it takes to grant or deny the request. The Certification of Need for Reasonable Accommodation and Third-Party Verification is not to be completed by the Head of Household or the requesting individual.

6. If your request involves a unit transfer, you may have additional forms to complete upon approval. If your request involves the addition of a Live-in Aide, you will need to complete Live-in Aide forms.

7. **Release of Information**: I had a full opportunity to read and consider the contents of this authorization, and by signing this form I give the HCHA permission to talk with my physician or other professional, reliable third party or Case Manager who has completed the verification for the reasonable accommodation requested. This authorization will expire six months from the date it is signed. I have the right to revoke this authorization at any time by giving written notice of my revocation to the HCHA.

By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are, to the best of my knowledge, true and accurate.

_____ _____

Signature of Applicant/Resident/Participant *Date*

Please return the completed both parts of the form together to:

Hernando County Housing Authority
621 W. Jefferson Street
Brooksville, FL 34601
kkamin@co.hernando.fl.us -or- dcoble@co.hernando.fl.us

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION AND THIRD-PARTY VERIFICATION

IMPORTANT: This section must be completed ONLY by a qualified medical, rehabilitation, or other knowledgeable third-party professional.

DO NOT RETURN THIS FORM UNLESS COMPLETED BY A MEDICAL PROVIDER.

Forms completed by the Applicant/Resident/Participant will be rejected.

Date: _____

Name of party requesting the Reasonable Accommodation: _____

Address _____

City_____ State_____ Zip: _____

Please return to the Hernando County Housing Authority, 621 W. Jefferson Street, Brooksville, FL 34601.
Telephone: 352-754-4160 Email: kkamin@co.hernando.fl.us -or- dcoble@co.hernando.fl.us

We are not inquiring as to diagnosis, treatment, or the extent and severity of the disability.

Explanation: The Hernando County Housing Authority (HCHA) is required by law to provide reasonable accommodations to disabled applicants, residents, and participants in its programs when the accommodations will facilitate their ability to function and provide equal opportunity to use and enjoy our housing programs. Applicable federal and state law defines "disability" with respect to the individual as (1) a physical or mental impairment which substantially limits one or more of such person's major life activities; (2) a record of having such an impairment; but such terms do not include current illegal drug use or addiction to a controlled substance, or an alcoholic who poses a direct threat to property or safety because of alcohol use. The following questions may help determine whether the applicant, resident or participant (or a member of the household) has a disability.

1. Name of Applicant/Resident/Participant: _____

2. In my professional opinion and assessment:

☐ **The Individual requesting the accommodation(s) has a disability** based on one or both of the following legal definitions: (please check each that applies)

☐ He/she has a physical or mental impairment that limits one or more major life activities; or

☐ He/she has a record of having such an impairment.

☐ **The Household Member requesting the accommodation(s) does not have a disability.**

3. Please check **only one** of the following:

☐ I certify that the Request for Reasonable Accommodation is necessary for the Applicant/Resident/Participant to have an equal housing opportunity as result of his/her disability.

☐ I do not certify/believe that the Request for Reasonable Accommodation is necessary for the Applicant/Resident/Participant to have an equal housing opportunity as result of his/her disability.

4. Please describe the relationship between the reasonable accommodation and the disability:

_____

_____

5. Please describe the participant's limitation. For example, if the limitation is:

- Unable to care for oneself, live-in aide or caretaker needed: please provide the particulars of services needed and the length of time (hours or days) that assistance is needed.
- Walking: please state what is the distance the applicant, resident or participant can walk. You may give distances and/or how long the applicant, resident or participant can stand.
- Lifting: please state the maximum pounds the applicant, resident or participant can lift and the maximum time limits.

_____

_____

6. Are there any other alternate accommodations or modifications that could meet the applicant's, resident's, participant's, or household member's needs in place of what the applicant, resident, participant or household member has requested?

_____

_____

7. How long have you been treating the household member? Please do not include specific details of treatment.

_____

8. Please state your qualifications or professional credentials to make this verification, please also list your Florida Medical License Number if you are a physician or licensed by the state:

_____

CERTIFICATION:

I understand that I may be contacted by HCHA's staff to verify the information I have provided or to provide further information/clarification regarding this request. Furthermore, I understand that I may be contacted or otherwise subpoenaed to provide testimony in a court of law, administrative hearing and/or other legal action with respect to the information I have provided herein or related to this document.

If not able to provide testimony, you must state the reason: _____

By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are to the best of my knowledge true and accurate.

_____ Signature

_____ Date

_____ Printed Name

_____ Phone

_____ Professional Title

_____ Fax