HIALEAH HOUSING AUTHORITY

75 EAST 6TH STREET, HIALEAH, FL 33010
PH: 305-888-9744 – FAX: 305-887-8738
TTY: 1.800.877.8339 • SPANISH: 1.800.845.6136

MAIDA GUTIERREZ, CHAIRPERSON
MARIO DIAZ, VICE-CHAIRMAN
FARA ALVAREZ, COMMISSIONER
BARBARA HERNANDEZ, COMMISSIONER
JUAN JUNCO, COMMISSIONER

JULIO PONCE
EXECUTIVE DIRECTOR

¡Este documento es importante, tradúzcalo inmediatamente!
Dokiman sa a enpotan, tradui Ii tousuit!

REASONABLE ACCOMMODATION REQUEST

HEAD OF HOUSEHOLD: ____ PHONE: (____) ________________________________

REQUESTOR: ____
(PERSON REQUESTING REASONABLE ACCOMODATION IF OTHER THAN HEAD OF HOUSEHOLD, PRINT NAME)

ADDRESS: ____TENANT NO.:___________________________

SIGNATURE: ____ DATE: _______________________________________
(HEAD OF HOUSEHOLD, OTHER REQUESTOR, OR AUTHORIZED REPRESENTIVE OF REQUESTOR)

A disability is defined, in part, as a physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment.

A Public Housing resident may request a change in his or her current unit or a transfer to a unit that has already been changed (in the resident's development or another development). An applicant, resident, or program participant may request assistance with, or change in, a Hialeah Housing Authority ("HHA") practice, rule, policy, procedure, program or service.

HHA will work with the applicant, resident or program participant to determine how to provide the reasonable accommodation request. HHA may require documentation to support the reasonable accommodation request(s).

1. The following is the name of the head of household or other members of the family with a disability who needs a reasonable accommodation:

   Name: _______________________________________

2. Because of the above household member's disability, the following change(s) or assistance (reasonable accommodation) is necessary so that the individual can participate in an HHA program as easily or successfully as other program participants.

   Check the kind of change(s) you need.

We are an equal opportunity housing provider. We do not discriminate on the basis of race, color, national origin, religion, sex, familial status or disability. This document is available in an alternate, accessible format upon request. Anyone who requires an auxiliary aid or service for effective communication, or a modification of policies or procedures to participate in a program, service, or activity offered by the Hialeah Housing Authority should contact the Section 504 Coordinator.

[ ] A change or special feature in a HHA dwelling, building or property. Note: If you are a Section 8 program participant, you must make these kinds of requests to your landlord.

[ ] Assistance with, or change in, a HHA practice, rule, policy, procedure, program or service.

3. Describe the problem that the household member named in item 1 is having, or might have, with a HHA dwelling, building, property, practice, rule, policy, procedure, program or service:____
____
____

4. Describe the type of change or assistance (reasonable accommodation) required :
____
____
____

5. Describe how this change or assistance will help with the problem:
____
____
____

6. Indicate the verification source HHA may contact to verify that the household member named in item 1 has a disability and needs a reasonable accommodation.

______________________________________ ____________________
Name of Health Care Provider/Documenting Authority Title

____
Company

______________________________________ ____________________
Address Telephone Number

____
City State Zip Code Fax Number

Note: Individuals may obtain a copy of the HHA Reasonable Accommodation Policies and Procedures, upon request, from Public Housing Site Managers, Section 8 Leasing and Contract Specialists, and the Section 504 Coordinator. You may also get additional copies of this request form from the Section 504 Coordinator:

Yinet Ortega
75 East 6th Street
Hialeah, Florida 33010
Phone: (305) 888-9744 Fax: (305) 882-5812 or (305) 887-2216

Warning: Title 18, US Code Section 1001, states that a person who knowingly and willingly makes false or fraudulent statements to any Department or Agency of the United State is guilty of a felony. State Law may also provide penalties for false or fraudulent statements.

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REASONABLE ACCOMMODATION AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Head of Household or other Household members with a disability: ________________________________
Print Name

I hereby authorize the release of information to Hialeah Housing Authority ("HHA") regarding the request for reasonable accommodation described on this form. This release shall constitute a limited authorization for the release of information, as described below.

I hereby authorize to consult with representatives of HHA, in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as an individual with a disability for the sole purpose of this reasonable accommodation request.

For purposes of this Release, a "Qualified Individual with a Disability" is defined as a person who has a physical or mental impairment that:

1. Substantially limits one or more major life activities
2. Has a record of such an impairment
3. Is regarded as having an impairment

"A Physical or Mental Impairment" is defined as:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the body systems including, but not limited to: neurological, musculoskeletal, special sense organs, respiratory, and speech organs or
2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

The term "Physical or Mental Impairment" includes, but is not limited to, such diseases and conditions as visual, speech and hearing impairments, epilepsy, multiple sclerosis, cancer, etc.

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"Major Life Activities" include 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 (mental or physical)" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Is Regarded as Having an Impairment" means:

1. Has a physical or mental impairment that does not substantially limit one or more major life activities, but is treated by a recipient as constituting such a limitation.
2. Has a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward the impairment.
3. Has none of the impairments defined by Section 504's definition of "physical or mental impairment", but is treated by a recipient as having such an impairment.

In addition, I authorize ____________________________________ (Name of Health Care Provider/Documenting Agency) to consult with representatives of HHA, in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as an individual with a disability for the sole purpose of this reasonable accommodation.

<u>This Authorization solely authorizes the release of information necessary to verify the following</u>:

1. Documentation necessary to verify that the person meets the definitions noted above;
2. A description of the needed accommodation; and,
3. A description of the identifiable relationship between my disability and the requested accommodation(s).

This Authorization for Release of Information should only seek information that is necessary to determine if the requested reasonable accommodation is needed because of a disability.

This Authorization does ***not*** authorize HHA to examine my medical records, including diagnosis or test result(s); nor does this authorize the release of detailed information about the nature or severity of my disability.

The information/documentation released as a result of this Authorization shall be kept confidential and not shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

____	________________________________
Print Name of Requestor/Head of Household or Legal Guardian asking for the accommodation	*Relationship* to *Person with Disability*
____	________________________________
Signature	*Date*

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<u>PLEASE PROVIDE THE FOLLOWING INFORMATION</u>:

______________________________________	____________________
Name of Health Care Provider/Documenting Authority	Title
______________________________________	
Company	
______________________________________	______________________
Address	Telephone Number
______________________________________	______________________
City State Zip Code	Fax Number

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JULIO PONCE
EXECUTIVE DIRECTOR

REASONABLE ACCOMMODATION VERIFICATION

HEAD OF HOUSEHOLD: ________________________________ TENANT NO.:________________
(PRINT NAME)

Re: Reasonable Accommodation Request

FOR: ____ TELEPHONE NO.:______________
(PRINT NAME OF HOUSEHOLD MEMBER FOR WHOM THE REQUEST IS BEING MADE)

PLEASE RETURN TO: ___________________________________ HHA PHONE: (305) 888-9744
(HHA EMPLOYEE NAME)

Hialeah Housing Authority
75 East 6th Street
Hialeah, Florida 33010

"PLEASE PRINT"

THE FOLLOW SECTION IS TO BE FILLED OUT BY THE DESIGNATED VERIFICATION SOURCE:

1. The individual seeking an accommodation is a person with a disability according to the following definition: *"Disability" is defined as a physical or mental impairment that substantially limits one or more major life activities; a record of having such impairment, or being regarded as having such impairment.*

   ☐ YES ☐ NO

2. Describe the problem(s) that the person is having with the HHA dwelling, building, property, practice, rule, policy, procedure, program or service:
   ____
   ____
   ____
   ____
   ____

3. Do (es) the person(s) making the reasonable accommodation meet the definition of disability as mentioned in 1. Above? __________________

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4. Describe the type of change(s), feature(s) or assistance required:
____
____
____
____

5. Please describe the relation between the person's functional limitation(s) and the requested accommodation. Do not provide unnecessary details about the medical history or disabled status of the person seeking an accommodation.
____
____
____
____

For Live-In-Aide request "ONLY" please answer the following questions:

1. Is a live-in-aide "essential" to the care and well-being of the patient?
□ Yes □ No Temporary basis □ duration ____________or Permanent □

2. If the response to question 1 is "Yes", then please explain what the live-in-aide would do that is "essential" to the patient care and well-being.
____
____
____

I___________________________, do hereby certify that the information provided above is correct
(Physician Name) and accurate to the best of my professional knowledge.

_________________________________ ______________________________________
Signature Date

Name of Organization/Practice_________________________________
Title of Verification Source_____________________________________
License Practice #:_______________ Address: ____
Telephone: _________________ Fax: _________________________

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