

HOUSING AUTHORITY OF THE BIRMINGHAM DISTRICT

REASONABLE ACCOMMODATION/REASONABLE MODIFICATION

REQUEST FORM

In certain instances, a person with a disability may be entitled to a reasonable accommodation or a reasonable modification. A reasonable accommodation is a change in the project's rules, policies, procedures or services which is necessary to ensure that the person with a disability has an equal opportunity to use and enjoy a dwelling or other areas of the project or to benefit from services provided to all residents. A reasonable modification is a physical modification to a dwelling unit or other part of the project which is necessary to afford a disabled individual an opportunity to equally use and enjoy a dwelling or other parts of the project.

Requests for a reasonable accommodation will be evaluated on a case-by-case basis and a decision whether to grant or deny the request will be made in accordance with provisions of applicable laws. We believe it is helpful if a request for a reasonable accommodation or physical modification is made in writing. Therefore, if you are disabled and believe that you require an accommodation in order to provide you an equal opportunity to enjoy your housing, please provide the information requested below:

NAME: _____

ADDRESS: _____

DATE OF REQUEST: _____

REQUESTED ACCOMMODATION (please briefly describe what it is you are seeking):

Before we can make a decision regarding whether a request will be granted, we will need to obtain written verification that the person seeking the accommodation is disabled as that term is defined in applicable law and that, because of the individual's disability, the requested accommodation is necessary to provide the person seeking the accommodation an equal opportunity to use and enjoy the housing. Accordingly, please identify a qualified professional who is in a position to verify both the existence of a disability and the need for that which is being sought. If the request is for an assistance animal, please identify a licensed health-care professional.

NAME OF QUALIFIED PROFESSIONAL or LICENSED HEALTH-CARE PROFESSIONAL:

ADDRESS OF QUALIFIED PROFESSIONAL or LICENSED HEALTH-CARE PROFESSIONAL:

PHONE NUMBER FOR QUALIFIED PROFESSIONAL or LICENSED HEALTH-CARE PROFESSIONAL: _____

Upon completion of the form, please return it to the manager. At that time, you will be asked to sign an authorization permitting management to send a Verification Form to the Qualified Professional or Licensed Health-Care Professional identified above. Once a decision whether to grant or deny the request has been made, the individual making the request will be notified in writing.

Thank you.