**Coastal Community Development Corporation "CCDC"**
**WORKFORCE HOUSING APPLICATION**
**REASONABLE ACCOMMODATION QUESTIONNAIRE**

**I (Applicant/Tenant)_____ request that reasonable accommodations are made in order for me to accurately complete the application/re-examination process. I do hereby certify that without the reasonable accommodations requested, I will not be able to complete my application/re-examiniation.**

**Check all that apply:**

**___Translator _____Type (English, French, Spanish etc)**
**___Sign Language Interpreter**
**___Power of Attorney**
**___Braile or Bold Print**
**___Other _____Please list**

**Applicant/Tenant Signature:_____ Date:_____**

**Witness:_____ Date:_____**

Coastal Community Development Corporation "CCDC"
WORKFORCE HOUSING APPLICATION
REASONABLE ACCOMMODATION FOR HOUSING QUESTIONNAIRE

A person with a disability(ies) may request a change, exception or adjustment to CCDC's rules, policies, practices, procedures or modifications to its housing units as a reasonable accommodation. Requesting an accommodation does not affect participation in the program. This form is to be completed and returned as part of the application and annual review process but can be requested and submitted at any time as needed. Contact the Program Manager with CCDC if assistance is needed in completing this form.

Head of Household Name: _____
Address: _____ Phone # _____
Other preferred contact information: _____

Please check the appropriate box, provide the information as necessary, sign the bottom, and submit with the full application.

1.Does anyone in your household need a reasonable accommodation?
No - If No, complete number 3 below
Yes - If Yes, complete numbers 1a, 1b, 2, and 3 below
1a. Print the name of the family member requiring the accommodation _____
1b. Describe the accommodation needed
_____
_____
_____
_____

2.Person who can verify the disability and the disability-related need for the accommodation, such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker,caseworker, or counselor).
3.Name: _____
Agency (if applicable): _____
Address: _____
Phone number: (____) _____ Fax number: (____) _____
4.E-mail (if known): _____
5.Signature: I certify the above information is correct:
Signature of Head of Household or Cohead: _____
Date:_____