

LAUREL OAK HOMEOWNERS ASSOCIATION, INC.
C/O LAS VERDES POA, 5121 LAS VERDES CIRCLE, DELRAY BEACH, FL 33484

Request for Reasonable Accommodation

You may utilize this form to request that LAUREL OAK HOMEOWNERS ASSOCIATION, INC. provide a reasonable accommodation to you, or a member of your household who has a disability

For purposes of this form, please refer to the attached "Reasonable Accommodation Policy" to determine whether you are a "qualified individual with a disability".

If you would like to request a reasonable accommodation on behalf of yourself or a member of your household, please complete this form. You must date and sign your name at the bottom of this form and return the form to the LAUREL OAK HOMEOWNERS ASSOCIATION, INC. If you need assistance in understanding whether you or a member of your household is a "qualified individual with a disability" or if you need assistance in completing this form, please contact your local Housing Authority.

Date of Request

Social Security Number

Name of Applicant/Resident/Participant

Telephone Number

Address

City/State/Zip Code

1. I am requesting the following reasonable accommodation(s): _____

2. I am requesting the reasonable accommodation(s) on behalf of: (name):

3. My reason(s) for requesting this reasonable accommodation: _____

4. A physician, licensed health care professional, professional representing a social service agency, disability agency or clinic must provide verification of your disability.

LAUREL OAK HOMEOWNERS ASSOCIATION, INC.

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Dear Resident/Applicant:

You have indicated that you, or a member of your household, need a reasonable accommodation because of a disability in connection with a villa unit located at LAUREL OAK HOMEOWNERS ASSOCIATION, INC. A physician, licensed health care professional, or a professional representing a social service agency or disability agency or clinic must verify this information.

Please take this letter and the attached *Authorization for Release of Information* to your health care provider or other appropriate individual, clinic or agency.

LAUREL OAK HOMEOWNERS ASSOCIATION, INC. will use this information to evaluate your request for a reasonable accommodation. LAUREL OAK HOMEOWNERS ASSOCIATION, INC. will keep this information confidential. If you choose not to authorize the release of this information, we may not be able to consider your reasonable accommodation request(s).

MODIFICATION/ACCOMMODATION REQUESTED:

LAUREL OAK HOMEOWNERS ASSOCIATION, INC.
C/O LAS VERDES POA, 5121 LAS VERDES CIRCLE, DELRAY BEACH, FL 33484

Authorization for Release of Information

RE: Household Member with Disability: _____

I hereby authorize _____ **[Insert name of health care provider or other appropriate documenting authority]** to consult with representatives of the LAUREL OAK HOMEOWNERS ASSOCIATION, INC., 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.

I hereby authorize the release of information to the LAUREL OAK HOMEOWNERS ASSOCIATION, INC. 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.

This Authorization solely authorizes the release of information necessary to verify the following:

- 1. Documentation necessary to verify that the above-named individual meets the definition of a “qualified individual with a disability”, as defined below;**
- 2. A description of the needed reasonable accommodation(s); and,**
- 3. A description of the identifiable relationship between the individual’s disability and the requested reasonable accommodation(s).**

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.

“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 _____ **[Insert name of health care provider or other appropriate documenting authority]** to provide only documentation that is necessary to verify that I meet the definition of a “Qualified Individual with a Disability”, as defined above. 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 LAUREL OAK HOMEOWNERS ASSOCIATION, INC. 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. Any information or documentation released as a result of this Authorization shall be kept confidential and will not be shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than twelve (12) months. There are circumstances that would require LAUREL OAK HOMEOWNERS ASSOCIATION, INC. to verify information that is up to five (5) years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

Date: _____

Name of Family Member/Parent/Legal Guardian [Print]

Signature

Relationship to Resident

PLEASE PROVIDE THE FOLLOWING INFORMATION:

(1) Name of Health Care Provider/Documenting Authority:

(2) Address of Health Care Provider/Documenting Authority:

(3) Telephone Number of Health Care Provider/Documenting Authority:

(4) Facsimile Number of Health Care Provider/Documenting Authority:

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Reasonable Accommodation Request Verification

Date: _____

To: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

Re: Request for Reasonable Accommodation

Member's Name: _____

Property Address: _____

The person named above has requested that LAUREL OAK HOMEOWNERS ASSOCIATION, INC. accommodate his/her disability by _____

_____.

Under normal circumstances, our policies would require us to deny the request. However, under federal law, if an individual with disabilities requests accommodation to that disability, we must consider the request. To do this, we must verify that the individual qualifies as disabled under federal law and requires the accommodation in order to have an equal opportunity to use and enjoy his/her home.

We would appreciate your cooperation in answering the questions on this form and returning it to the address listed above.

DEFINITION OF “DISABLED”

A person is considered handicapped/disabled under state and federal laws if he or she has, a physical or mental impairment which substantially limits one or more of his or her major life activities such as seeing, hearing, walking, speaking, learning, breathing, eating or performing manual tasks; a record of having such impairment; or is regarded as having such impairment.

In a joint statement in 2004, the U.S. Department of Housing and Urban Development (HUD) and the Justice Department explained that physical or mental impairments include, but are not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV, mental retardation, emotional illness, drug addiction (excluding an addiction caused by current, illegal use of a controlled substance) and alcoholism.

INFORMATION REQUESTED

1. Is **[Insert name of Resident]** _____ disabled as defined on this page?

☐ Yes

☐ No

2. If you answered “Yes” to question number one, can **[Insert name of Resident]** _____ condition be treated to prevent any substantial limits in any of his/her major life activities?

3. **[Only if the disability is not evident]** What disability does **[Insert name of Resident]** _____ suffer from?

4. What “major life activities” are limited by this disability?

5. How will the Association's granting of the reasonable accommodation help **[Insert name of Resident]** _____?

6. Please demonstrate the relationship between the person's disability and the need for the requested accommodation.

7. In your professional opinion, does **[Insert name of Resident]** _____ need the accommodation requested in order to have the same opportunity that a non-disabled individual has to use and enjoy his/her home?

☐ Yes

☐ No

8. Since what date has **[Insert name of Resident]** _____ been under your care?

9. How many times have you seen **[Insert name of Resident]** _____ as a patient, and on what dates? (please limit your response to the last twelve (12) calendar months).

NAME AND TITLE OF PERSON SUPPLYING INFORMATION:

FIRM/ORGANIZATION:

Would you be willing to testify in any court action or related proceeding as to **[Insert name of Resident]** _____ need for the requested accommodation?

☐ Yes

☐ No

HEALTH CARE PROVIDER'S SIGNATURE: _____

MEDICAL LICENSE NUMBER (IF PHYSICIAN): _____

DATE: _____