



HCV Program
1300 Broad Street N
Jacksonville, FL 32202
Phone: 904-552-5952
HCVCustomerService@jaxha.org
JaxHA.org

REQUEST FOR REASONABLE ACCOMMODATION

Date of Request: _____

Name of Applicant/Participant/Resident (Head of Household):

Name: _____

Address: _____

Phone: _____

Name of Applicant/Participant/Resident needing the accommodation:

☐ Head of Household

☐ Family Member

(Name)

Things to consider before completing and submitting your Reasonable Accommodation Request:

1. An individual with a disability is defined as: "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment."

a. In general, a physical or mental impairment includes: hearing, mobility and visual impairments, chronic alcoholism, chronic mental illness, AIDS, AIDS Related Complex, and intellectual disability/intellectual developmental disorder that substantially limits one or more major life activities. Major life activities include walking, talking, hearing, seeing, breathing, learning, performing manual tasks, and caring for oneself.

b. **Having a temporary ailment does not qualify an individual as having a disability.** Examples of conditions that are **NOT** impairments includes: The common cold or the flu, a sprained joint, minor and non-chronic gastrointestinal disorders, a broken bone that is expected to heal completely and pregnancy.

2. A "reasonable accommodation" is a change, exception, or adjustment to a rule, policy, practice or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common-use spaces. Since rules, policies, practices and services may have a different effect on persons with disabilities than on other persons, treating persons with disabilities exactly the same as others will sometimes deny them an equal opportunity to use and enjoy a dwelling [Joint Statement of the Departments of HUD and Justice: Reasonable Accommodations under the Fair Housing Act].

"If you or anyone in your family is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, please contact the housing authority."



3. JHA reserves the right to verify at annual reexamination that the reasonable accommodation is being utilized and/or the continued medical necessity for the reasonable accommodation.

Reasonable Accommodation Request (To be completed by Applicant/Resident/Participant)

Indicate what reasonable accommodation(s) that you are requesting: Accommodations can include a change in your voucher or an adjustment to rules, communication methods, and/or procedures of the HACFL.

Note: Please do not list your medical diagnoses. I am requesting (check all that apply):

Extension of Voucher

Waiver on relative owner prohibition

Additional bedroom for disabled person

Live-in Aide

Extra time to locate a unit due to disability reasons

Change in the Payment Standard

Additional Utility Allowance (for medical equipment that uses electricity)

Additional bedroom for medical equipment

Special communication needs for either persons with visual impairments (written material in alternate language formats, such as large print) or hearing impairments (sign language interpretation services at meetings with HACFL)

Other policy or rule change needed. Please explain:

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



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Knowledgeable Professional Information

Please list the contact information of the knowledgeable professional who can verify that you have a disability warranting the accommodation(s). If you do not provide the contact information for a knowledgeable professional, this request may be deemed incomplete. Providing a fax number or email address for the knowledgeable professional may result in your request being processed more quickly.

Name: _____ Title: _____

Address: _____

Telephone Number: _____ Fax or Email: _____

I hereby understand and acknowledge:

1. That I had a full opportunity to read and consider the contents of this authorization and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information as described in this form.
2. That the information obtained under this consent is limited to information that is no older than 12 months.
3. I do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.
4. That the third party listed above has knowledge of whether my disability requires a reasonable accommodation or modification. To verify an accommodation or modification, a request may be made from the third party for only the minimum information necessary to confirm such accommodation or modification is required. Any other request for information about me is not relevant and may not be made (e.g., diagnosis; treatment).
5. The authorization will expire one (1) year from the date it is signed.
6. I have a right to revoke this authorization at any time by giving written notice of my revocation to the entity listed in Section B. I understand that revocation will not affect any action already taken in reliance on this authorization.
7. I am entitled to a copy of this authorization after I sign it.
8. The information provided on this form is true and accurate. I give JHA permission to discuss the requested accommodation with my knowledgeable professional.

Note: The knowledgeable professional listed above will receive a copy of this form.

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Signature of Participant _____ Date _____

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the legal documents:

Personal representative's name: _____

Relationship to the individual: _____

Fraud and False Statements: I/We, the undersigned, certify under penalty of perjury that the information provided here is true and correct, to the best of my knowledge and recollection. WARNING: Anyone who knowingly submits a false claim or knowingly makes a false statement is subject to criminal and/or civil penalties, including confinement for up to 5 years, fines, and civil and administrative penalties.
(18 U.S.C. 287, 1001, 1010, 1012; 31 U.S.C. 3279, 3802)