



**REQUEST FOR REASONABLE
ACCOMMODATION OR MODIFICATION**

Name of Head of Household

Client ID Number (if available)

Address

City/ State/ Zip

Telephone Number

1. Reasonable accommodation requested for: _____
Name of Household Member with Disability

2. Reasonable accommodation requested: _____
What

3. Reason for requesting this accommodation: _____
Why

4. Provide independent documentation needed to verify the existence of your disability, related to the need for the accommodation, from your doctor, licensed professional or other professional competent to render opinion (use other side of this form, or provide other documentation).

5. I certify that the information in this Request for Reasonable Accommodation is true and accurate.

Signature of Applicant/Resident/Participant

Date of Request

IMPORTANT! This side of the form must be completed by a doctor or licensed professional.

This side may not be completed by the Applicant, Resident or Participant.

REASONABLE ACCOMMODATION VERIFICATION

Independent verification to be completed by a doctor, licensed professional or other professional who is knowledgeable about the person's disability and competent to render the opinion.

Explanation: The WHA is required by law to provide reasonable accommodations to disabled applicants, residents, and participants that will facilitate their ability to function and provide equal opportunity to use and enjoy WHA housing programs. Applicable federal and state law defines "disability," with respect to the individual, as: (1) a physical or mental impairment which substantially limits one or more of such person's major life activities; (2) a record of having such an impairment; (3) being regarded as having such an impairment; but such term does not include current, illegal drug use or addiction to a controlled substance. Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning, working, thinking, eating, standing, lifting, concentrating, communicating, and sleeping.

Printed Name of Applicant/Resident/Participant

Printed Name of Doctor/Licensed Professional

Professional Title

Telephone Number

Business Address

City, State, and Zip Code

Please indicate in your professional judgment whether the person requesting the accommodation or modification has a disability as defined in the box above.

Yes No Not Sure

Does the applicant/resident have a disability-related need for the accommodation based on the physical or mental impairment? Please explain your response in the space provided:

Signature

Date

REQUEST FOR REASONABLE ACCOMMODATION OR MODIFICATION

Note: This form may be submitted to the Worcester Housing Authority at any time.

If you need assistance with this form or have additional questions, please contact the WHA at (508) 635-3000.

