Housing Authority of the Town of Portland
9 Chatham Court, Portland, CT 06480
P#:(860) 342-1688 / F# (860) 342-3961
Website: www.portlandha.org

Dear Resident/Applicant:

You have indicated that you, or a member of your household is disabled and in connection with the disability requires a specific change in rules, policies, and procedures and methods of communication or may have asked for physical modifications to a unit or common area to enable you or a member or your household access to a building, unit or program. This request is a called a Reasonable Accommodation Request. Individuals may submit their reasonable accommodation request(s) in writing, orally, or by any other equally effective means of communication. However, PHA will ensure that all reasonable accommodation requests will be reduced to writing. If needed as a reasonable accommodation, PHA will assist the individual in completing the Reasonable Accommodation Request Form.

A physician, licensed health care professional, or a professional representing a social service agency or disability agency may verify this information. Please take this Reasonable Accommodation Request Form to your health care provider or other appropriate individual. Once this information is received, we will use the information to evaluate your request for a reasonable accommodation. We will keep this information confidential.

The Portland Housing Authority will try to make the changes provided that the request is reasonable, it does not create an undue administrative or financial burden for the property, and it does not change the fundamental nature of the program under which the property is regulated. PHA will make the best efforts to make a decision within thirty (30) days from the date of this request. We will notify you if it is not possible to make a decision within thirty (30) days in writing and inform you why it is not possible. We will also notify you if more information or verification is required or if a meeting is required to discuss other ways to meet the request.

If you have any, questions pertaining to the Reasonable Accommodation request you may contact our Administrative Housing Assistant at (860) 342-1688 ext.110.

Sincerely,

Allen Harrison
Allen Harrison
Executive Director

Para una traduccion en espanol por favor llame a la oficina (860) 342-1688
The Portland Housing Authority is an Equal opportunity Affirmative Action Employer

This form is intended for use by residents/applicants of the Portland Housing Authority (PHA) and/or Property Manager to request a reasonable accommodation in a rule, policy, procedure, or a physical modification because of their disability or a family member's disability. This form may be filled out by the resident/applicant with a disability unless the individual cannot as a direct result of his/her disability. In this case the resident/applicant's designee may fill out the form. This form may also be used by Property Management to document a verbal request for a reasonable accommodation. Please let PHA staff know if you need assistance in filling out this form.

Date of Request: _____

Signature of Director if Need for Accommodation is Verbal or Observed: _____

Are you currently a resident or applicant on the waitlist? _____

Name of Head of Household: _____

Address: _____ Phone: _____

Name of resident/applicant needing the accommodation, if different from above:

_____

1. The following member of my household has a disability as defined below: Definition of disabled: Under federal law, an individual is disabled if he/she 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. The term physical or mental impairment includes, but is 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, H.I.V., mental retardation, emotional illness, drug addiction and alcoholism. This definition does not include any individual who is a drug addict and is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use. Under state law, physically disabled is defined as "any individual who has any chronic physical handicap, infirmity or impairment, whether congenital or resulting from bodily injury, organic processes or changes from illness, including, but not limited to, epilepsy, deafness or hearing impairment or reliance on a wheelchair or other remedial appliance or device". Under state law mentally disabled is defined as, "an individual who has a record of, or is regarded as having one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders."

2. As a result of this disability, request the following change(s), which is called a "reasonable accommodation", so that I can have equal access to and enjoyment of my apartment or other facilities: or services at the site. Check the kind of change{s) you need:

3. As a result of this disability, request the following change(s), which is called a "reasonable accommodation", so that I can have equal access to and enjoyment of my apartment or other facilities: or services at the site. Check the kind of change(s) you need:

( ) A repair or change in my apartment
( ) A repair or change to some other part of the property .
( ) A change in the rules, policies or procedures
( ) A change in the way we communicate with you

4. This reasonable accommodation is necessary because:

_____

_____

_____

_____

_____

_____

_____

5. If necessary, you may verify that the person named above meets the definition of disabled (not what the disability is) and the need for this request as a direct result of the disability by contacting the medical. professional or service provider listed below: (Give name, address, and phone number of a knowledgeable professional):

Name: _____

Title: _____

Address: _____

Phone: _____

*Please note that the knowledgeable professional named above will receive a copy of this: form. Additionally, PHA may contact the identified knowledgeable professional for further verification and/or clarification of information provided.

Signature: _____ Date: _____

Date: _____

To: Name of Health Care Provider: _____

Address:_____

Re: Name of Patient: _____

Address:_____

Dear Medical Professional:

The person identified above has submitted the attached request for an accommodation. They have given us permission to contact you to verify that he/she meets the definition of a person with a disability for purposes of a reasonable accommodation and that his/her request is necessary in order to have equal access to housing or programs. Attached please find a Disability Verification for Reasonable Accommodation Form along with a signed consent form requesting you answer the questions. Your prompt return of this information will assure timely processing of their request.

State and federal laws require housing providers to make reasonable accommodations or changes to either their apartment, other parts of the housing complex, or to house rules, policies or procedures if such changes are necessary to enable a person with a disability to have equal access to and enjoyment of the apartment and other facilities or programs at the site. Please note that such changes must be necessary to remove some physical or administrative barrier directly resulting from the person's disability.

Please indicate on the form whether you believe the individual has a disability within the definition provided and whether the accommodation is necessary and will achieve its stated purpose. You must indicate the nexus between the disability and the requested accommodation.

If part of the resident/applicant's reasonable accommodation plan includes services to be provided by your organization, please indicate whether your organization will provide these services.

This form should not be used to discuss the person's diagnosis or any other information that is not directly relevant to the request for an accommodation. Please do not send any medical records.

Sincerely,

Carol Diaz

Carol Diaz
Administrative Housing Assistant
860-342-1688 ext 110
9 Chatham Court
Portland, CT 06480
Cdiaz@ Portlandha.org

RELEASE OF INFORMATION

Resident Name: _____

Disabled Family Member (if different than above): _____

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

_____

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

_____

(3) Phone and Fax Number of Health Care Provider/Documenting Authority:

_____

Release: I give you permission to the PHA representatives to contact the above individual or agency, 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 purposes of this reasonable accommodation request.

I understand that the information you obtain will be kept completely confidential and used solely for the purpose of determining if you will provide an accommodation.

The Portland Housing Authority does not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, its federally assisted programs and activities.

Signed:_____ Date:_____

PENALTIES FOR MISUSING THIS CONSENT

Title 18, Section 1001 of the US Code states that a person is guilty of a felony for knowingly and willingly making false statements to any Department of the United States Government. HUD and any owner (and any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures of improper uses of information collected based on consent forms. Use of the above information collected on the basis of this verification is restricted for the purposes cited above. Any person who knowingly or willingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more-that $5,000.00. An applicant or participant affected by negligent disclosure of information may bring a civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at 42.U.S.C. 208(f (g) and (h).. Violations of these provisions are cited as violations. of 42 U.S.C. 408, f, g and h.

DISABILITY VERIFICATION

*1.In my professional opinion, the resident/applicant has a disability as defined below:

[ ] Yes. (Proceed to question #2)

[ ] No. (Proceed to signature section.)

[ ] I have insufficient knowledge regarding this person or situation.(Proceed. to signature section.)

Definition of disabled: Under federal law, an individual is disabled if he/she 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.an impairment. The term physical or mental impairment includes, but is 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, HJ.V., mental retardation, emotional illness, drag addiction and alcoholism. This definition does not include any individual who is a drug addict and is currently using illegal drugs or an alcoholic who poses 'a direct threat to property or safety because of alcohol use.

Under state law, physically disabled is defined as "any individual who has any chronic physical handicap, infirmity or impairment, whether congenital or resulting from bodily injury, organic processes or changes from illness, including, but not limited to, epilepsy, deafness or hearing impairment or reliance on a wheelchair or other remedial appliance or device". Under state law mental disabled is defined as, "an individual who has a record of, or is regarded as having one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders."

*2. Please describe how this disability restricts the resident/applicant in activities that are central to his/her daily life:_____

_____

_____

_____

*3. In my professional opinion:

The resident/applicant, as a result of his/her disability, requires the changes to policies and procedures as described in the attached request in order to remove barriers to equal housing access. If this is a request for a Live-in aide, please list what are the necessary supportive services that the Live-in companion/aide are expected to provide;_____

_____

_____

OR [ ] The resident/applicant, as a direct result of his/her disability, requires the following type of unit or change to the apartment or common area in order 'to remove barriers to equal housing access. Please indicate below, if you know, where any specialized equipment may be obtained or necessary:_____

_____

OR [ ] The resident/applicant, as a direct result of his/her disability, does not require the changes to. the apartment or common area or ta policies and procedures as described in the request in order to remove barriers to equal housing access.

OR [ ] I am unable to verify that the requested accommodation is necessary for the above-named person as a direct result of his/her disability to remove barriers to equal housing access.

*4.Please describe how this type of accommodation will enable the resident/applicant to have equal access to his/her apartment. (The nexus between the disability and the requested accommodation must be clearly stated):

_____

_____

_____

_____

All questions with * sign must be answers, do not leave any question blank. By signing this disability verification form, I agree to testify in any civil or administrative proceeding regarding the information provided above.

Printed Name of Medical Provider: _____

Signature: _____ *Phone #:* _____

Title: _____ Date: _____

PENALTIES FOR MISUSING THIS CONSENT

Title 18, Section 1001 of the US Code states that a person is guilty of a felony for knowingly and willingly making false statements to any Department of the United States Government. HUD and any owner (and any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on consent forms, use of the above information collected on the basis of this verification is restricted for the purposes cited above. Any person, who knowingly or willingly requests, obtains or discloses any information under false pretenses: concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000.00. An applicant or participant affected by negligent disclosure' of information may bring a civil-action for damages. and seek other relief as may be appropriate, against the. officer or employee of HUD or the owner responsible for the unauthorized: disclosure or improper use, Penalty provisions for missing the social security number are contained in the Social Security Act at 42 U.S.C. 208(f) (g) and (h). Violations of these provisions are cited violations of 42.U.S.C. 408, f, g and h.

APPROVAL/ DISAPPROVAL OF RESIDENT/APPLICANT

Resident/Applicant Name: _____ Date: _____

Address:_____

Dear Resident/Applicant:

We have completed the review of your request for a reasonable accommodation, the following is the outcome of the review:

( )We approve the request.

( )We approve the request with the following modification (s).

( )We are unable to approve the request because you do not meet the definition of a person with a disability. Therefore, we are not required to provide a reasonable accommodation.

( )We are unable to approve the request because it will fundamentally change the nature of our program.

( )We are unable to approve the request because it will create an undue financial of administrative hardship for us or is not structurally feasible.

( )We are unable to approve the request because there is no identifiable nexus between the requested accommodation and the disability.

You have the right to appeal this decision. A request for an informal hearing must be made to our Administrative Office within 14 days.

Maintenance Coordinator Recommendation:

_____

_____

_____

Signature: _____ Date: _____

Executive Director Recommendation:

_____

_____

_____

Signature: _____ Date: _____

This request was reviewed, and its recommended action authorized by:

_____ _____

Executive Director Date