For EHA Use Only

Is this request for an Annual Recertification?

Yes ☐ No ☐

CS Initials ____

REQUEST FOR REASONABLE ACCOMMODATION

This Form Is Available In Larger Font or Alternative Format Upon Request

The purpose of a Reasonable Accommodation is to remove or relieve a housing barrier posed by a disability-related limitation. Please complete the following form and return at your earliest convenience.

Name: _____TDD / Phone: _____

Address: _____

Name of person with a disability requesting Reasonable Accommodation: _____

Date of Birth: _____ Client Number: _____

Please be aware of the following while completing this request:

- Please refrain from sending us the medical records of the individual requesting an accommodation.
- Please refrain from including any details which disclose the nature or severity of the individual's disability. This information is not necessary to verify the needed request.

As a result of this disability, the following accommodation is requested. Please check one or more items.

☐ A Live-In-Aide is necessary to afford the Household Member equal use and enjoyment of the dwelling unit. Please complete the following statement.

A daily in-home worker, or rotating shifts, are not equally effective as a Reasonable Accommodation because:

_____

_____

_____

☐ Other (e.g. extra bedroom for medical equipment will be verified annually through HQS inspection, exclusive bedroom, payment standard, Service Animal, or a change in the way the PHA communicates with you). Please specify:

_____

_____

_____

☐ An accommodation to the following rule, policy, or procedure. Please specify:

_____

_____

_____

Return to: Everett Housing Authority 3107 Colby Avenue P.O. Box 1547 Everett, WA 98206-1547
PHONE #: 425-258-9222 FAX #: 425-303-1175 EMAIL: accommodations@evha.org

EQUAL HOUSING OPPORTUNITY

EVERETT
Housing Authority
Serving the Everett community since 1942

I am requesting this accommodation because:

_____

_____

_____

If you are requesting an extra bedroom for medical equipment, please list your pieces of equipment below:

_____

_____

The disability and the need for this request may be verified by contacting:

Name of knowledgeable professional: _____Title: _____

Agency / Facility: _____

Address: _____ City / State / Zip: _____

Phone: _____ Fax: _____

You may present verification directly to the housing authority. Please return this form as promptly as possible so that the housing authority may make a determination on this request.

I give you permission to contact the above individual for purposes of verifying that I, or a family member (s), have a disability and need the reasonable accommodation requested above. In order to verify this information, Everett Housing Authority may contact the following knowledgeable professional whose function is provide services to the disabled, or other expert. I understand that the information you obtain will be kept completely confidential and used solely to determine whether or not reasonable accommodation will be provided.

Printed Name: _____

Signature: _____ Date: _____
(Head of household or authorized representative)

**If on behalf of a minor child, please indicate whether you are the parent or guardian. Where the individual with the disability is over 18 and is not the head of household, he or she should sign the authorization verification.*

Return to: Everett Housing Authority 3107 Colby Avenue P.O. Box 1547 Everett, WA 98206-1547
PHONE #: 425-258-9222 FAX #: 425-303-1175 EMAIL: accommodations@evha.org

EQUAL HOUSING OPPORTUNITY