DISABILITY COMPLIANCE OFFICE
100 Ross Street, 4thFloor
Pittsburgh, PA 15219
Telephone: 412.456.5282
TTY: 412.201.5384
Facsimile 412.471.0964

To whom it may concern,

We acknowledge your intent to request a Reasonable Accommodation today. To process your request, we need third-party verification of your disability-related need. Please know, that HACP never inquires into the nature or extent of your disability. The HACP does need verification that your request is related to your disability and removes a barrier you face to housing.

Today, we are mailing you the Request for Reasonable Accommodation Form. Once we receive the completed verification form back from your third-party verifier, we will review your request. **Please return the third-party verification of your disability-related need within 15 days from the date of this letter.**

If you have any questions, you may contact the Disability Compliance Office at 412-456-5282 ext 2.

Sincerely,

Housing Authority of the City of Pittsburgh
Disability Compliance Office

Housing Authority of the City of Pittsburgh

DISABILITY COMPLIANCE OFFICE
100 Ross Street, 4th Floor
Pittsburgh, PA 15219
Telephone: 412.456.5282
TTY: 412.201.5384
Facsimile 412.471.0964

REQUEST FOR A REASONABLE ACCOMMODATION VERIFICATION FORM HOUSING CHOICE VOUCHER (HCV) Program

Instructions (please review carefully)

(1) The individual or family member should check off the boxes and fill out the blanks as appropriate regarding their request(s).

(2) The third party professional (such as a doctor/nurse, social worker, or service agency counselor) initials the corresponding selection, if the checked item in the professional's opinion, is needed due to the individual's or family member's disability. Attach supplemental information if necessary for any requests. Do not include any information about the nature or extent of the person's disability**. DO NOT SEND MEDICAL RECORDS.**

(3) The third party professional "MUST" complete and sign the form as directed.

(4) All requests with complete verification documents will be responded to within 30 days of receipt of the completed documents. If the request is denied information will be provided on the right to grieve the denial.

(5) Please note: this form should be returned within 15 days from the date the requester received it.

Please Complete Release of Information:

Applicant/Participant _____ Date of Birth: _____
(Print the name of the person with the disability)

I currently reside at_____.
(Print patient's full address:)-street apt. no. city state zip code

My phone # _____ Name of the Head of Household _____

By signing this release, I authorize _____
(Name of Third Party Professional, i.e. nurse, social worker, doctor)
to release information to the HACP to verify my disability and the need for an accommodation.

Applicant/Participant/Guardian (sign name) _____ Date: _____

******If this is for a child with disabilities please print Guardian's name* _____
and Guardian should sign above.

If you are in need of additional assistance or an alternate means of reviewing and understanding this process, please contact the Disability Compliance Staff at 412-456-5282.

NAME OF APPLICANT/PARTICIPANT _____

SPECIAL ACCOMMODATIONS NEEDED:

❑ Extra time to locate a unit due to disability related reasons. (Please explain why additional time to find a unit is needed due to the person's disability.) **Professional Initial Here:** _____

_____

_____

❑ Assistance to locate an apartment is needed because of a disability. (Please explain why assistance is needed due to the person's disability.) **Professional Initial Here:** _____

_____

_____

❑ Additional utility allowance **Professional Initial Here:** _____
(for medical equipment that uses extra electricity)

Specify equipment_____

❑ Separate bedroom for disability related equipment (Please list) **Professional Initial Here:** _____

_____

❑ Special accommodations for visual impairments **Professional Initial Here:** _____
(Please specify what is needed)

_____

❑ Special communication needs for the deaf/hard of hearing. **Professional Initial Here:** _____

- o Sign Language Interpreter
- o Other_____

❑ Other (explain). **Professional Initial Here:** _____

_____

_____

_____

❑ **EXTRA BEDROOM FOR LIVE-IN AIDE:** This individual requires LIVE-IN assistance related to disability not just visiting help. This is not verification for aides who come & go such as a caregiver that works specific shifts during the day or night on a regular basis. A live-in aide must meet this HUD definition: A live-in aide is a person who resides with one or more persons with disabilities and who: (1) Is determined to be essential to the care and well-being of the person(s); (2) Is not obligated for the support of the person(s); and (3) Would not be living in the unit except to provide the necessary supportive services.
Please describe the duties of your aide below. **Professional Initial Here:** _____

_____

_____

_____

NAME OF APPLICANT/PARTICIPANT _____

FOR PROFESSIONAL TO COMPLETE

In my professional opinion, the above individual a) has a disability as defined below which creates a barrier to access HACP housing/housing assistance and related programs and services, and b) the requested special features, modifications, and/or change(s) to HACP policy(s) listed above are required to address those barriers in order to allow the above individual full access to HACP housing and related programs and services. ***The Fair Housing Act defines a person with a disability as (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; and (3) individuals with record of such an impairment.***

Name (print):_____

Title:_____

Organization Name and Address:_____

Phone:_____ Fax:_____ Email: _____

Person to contact with questions about form:_____

I certify that the information I am providing is accurate and true to the best of my knowledge based on my professional training and experience.

Signature of Professional:_____Date:_____

The certifying professional should return this form to:

DISABILITY COMPLIANCE OFFICE

Fax Number: 412.471.0964 or Email: ra@hacp.org

Note: It is important that all 4 pages need to be completed and returned

within 15 days from the date the requester received them.