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
ra@hacp.org

To whom it may concern,

We acknowledge your intent to request a Reasonable Accommodation today. To process your request, we need your third party professional to verify that you are a person who needs the features of a fully accessible wheelchair unit. In order to be on the waiting list for a fully accessible wheelchair unit for the Lemington Senior Homes, the HACP will need verification that you need this unit type and that it will help remove barrier(s) you face in housing.

Enclosed is a 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
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LEMINGTON SENIOR HOMES

REASONABLE ACCOMMODATION VERIFICATION FORM
PROJECT BASED VOUCHER (PBV) 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 requested it.

Please Complete Release of Information:

NAME OF WAIT LIST COMMUNITY: LEMINGTON SENIOR HOMES

Applicant _____ 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 my information to the HACP to verify my disability and the need for an accommodation, and for HACP to release this information to any housing provider to which I have applied for housing and I am an applicant and/or participant of the Project Based Voucher Program. This information would be shared only in order to assist in processing and assessing my need for reasonable accommodation requests.

Applicant/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:

Please Explain Why The Features of A Fully Accessible Wheelchair Unit Are Required

- ❑ Fully wheelchair accessible unit (explain below) **Professional Initial Here: _____**

_____

_____

_____

- ❑ Features of an audio / visual unit **Professional Initial Here: _____**
- ❑ Special communication needs for the deaf/hard of hearing **Professional Initial Here: _____**
  - o Sign Language Interpreter
  - o Other_____

- ❑ Other (explain). **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 3 pages need to be completed and returned within 15 days from the date the requester received them.