HACP Disability Compliance

412 Blvd of the Allies, 6Th Floor
Pittsburgh, PA 15219
Telephone: 412-456-5282
Facsimile: 412-471-0964
TTY: 711
Department Email: 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 has an auditory and/or visual disability and needs the features of an audio / visual unit. In order to be eligible as an applicant on the waiting list for the **Mackey Lofts Apartments**, the HACP does need verification that you need the features of an audio / visual unit and this unit type that will help removes a barrier(s) you face in housing.

Please understand this is not a Low-Income Public Housing, Housing Choice Voucher Program, or Project Based Voucher application. If you need to apply, please do so by visiting hacp.org and click apply for housing then download the application form, or call 412-456-5030, or visit the One Stop Shop which is located at 412 Blvd of the Allies, 1st., Floor Pittsburgh, PA 15219.

Any signatures that are not of the or the head of the household or the household member or a verified POA or the Third-Party Professional will not be accepted.

Once we receive the completed verification form back from your Third-Party Professional, we'll review your request. **Please return this form 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.

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MACKEY LOFTS

REQUEST FOR A REASONABLE ACCOMMODATION VERIFICATION FORM
Project Based Voucher (PBV) Program

Instructions (please review carefully)

1. **THIS IS NOT A LOW-INCOME PUBLIC HOUSING, HOUSING CHOICE VOUCHER OR PROJECT BASED VOUCHER APPLICATION.** Please contact our occupancy team (412-456-5030), visit hacp.org and click on apply for housing then download the application form, or visit the One Stop Shop.

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

3. 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 OR DISCLOSE MEDICAL DIAGNOSIS.**

4. The third-party professional **MUST** complete, initial, and sign the form as directed.

5. 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.

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

Please Complete Release of Information:

Applicant/Voucher Holder/Participant: _____ Date of Birth: _____
(**Print the name of the person with the disability**)
Applicant/Voucher Holder/Participant Head of Household: _____

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

My phone #: _____ Email Address:_____

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/POA (sign name): _____ Date: _____

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

Revised Date: 08/2025

NAME OF APPLICANT/PARTICIPANT _____

SPECIAL ACCOMMODATIONS NEEDED:

- ☐ Features of an audio / visual unit **Professional Initial Here:** _____
- ☐ Fully wheelchair accessible unit **Professional Initial Here:** _____
- ☐ Special communication needs for the deaf/hard of hearing **Professional Initial Here:** _____
  - ☐ Sign Language Interpreter
  - ☐ Other: **(EXPLAIN)** _____
- ☐ Extra bedroom for medical equipment **Professional Initial Here:** _____
  (SPECIFY ALL EQUIPMENT AND ALL OF THEIR DIMENSIONS)

_____

_____

_____

- ☐ Additional utility allowance **Professional Initial Here:** _____
  (MEDICAL EQUIPMENT THAT USES ELECTRICITY)

SPECIFY ALL EQUIPMENT: _____

_____

- ☐ **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:** _____

_____

_____

_____

- ☐ Other Requests: **(EXPLAIN BELOW)** **Professional Initial Here:** _____

_____

_____

_____

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 a 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. ***

Signature:

Email: ra@hacp.org