

REQUEST FOR REASONABLE ACCOMMODATION



You may use this form to request Fort Worth Housing Solutions provide a reasonable accommodation to you or any member of your household who has a disability, so that you or a member of your household may utilize your residence or any FWHS facility, program or service.

The definition of a person with a disability is: Anyone with a physical, mental or emotional impairment which substantially limits one or more life activities, a record of having such an impairment, or being regarded as having such an impairment.

If you would like to request a reasonable accommodation on behalf of yourself or a member of your household, please complete this form. You must date and sign your name on the form and return in person or by mail or fax to:

Housing Choice Voucher Program
Annie Nelson, Operations Supervisor
FAX: 817-333-3620

Special Programs
Lanesha Davis, Program Administrator
FAX: 817-333-3633

Public Housing
Property Manager Office

Project Based Rental Assistance or RAD
Property Manager Office

If you need assistance understanding if you or a member of your household is a qualified person with a disability, or if you need assistance completing this form, please contact the staff above who represent the housing program you have applied for or participate in.

A physician, licensed health care professional, or a licensed professional representing a social service agency, disability agency or clinic may provide verification of your disability.

FWHS may not grant a reasonable accommodation if one of the following would occur: A violation of Federal or State law, a fundamental alteration of the nature of the FWHS housing program, an undue financial or administrative burden on FWHS, a structurally infeasible alteration, or an alteration requiring the removal or alteration of a load-bearing structural member.



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Name: _____

TDD/Phone: _____

Address: _____

City/State/Zip: _____

I am currently:

An applicant for housing assistance

Receiving housing assistance from FWHS

The following household member has a disability that qualifies under the 504/Fair Housing/ADA definition, which is: A physical, mental or emotional impairment which substantially limits one or more life activities, or a record of having or being regarded as having such an impairment.

Print household member's name: _____

As a result of my/his/her disability, the following accommodation is requested so that I/he/she can have the opportunity to equally participate in housing programs at FWHS:

Live-In Aide

Subsidy (Bedroom Size) Exception

Mail-In Recertification

Assistive Animal

Additional Bedroom for Medical Equipment

Other _____

FWHS may verify the disability and the need for the accommodation by contacting the following medical professional:

Name: _____ Title: _____

Phone: _____ FAX: _____

Address: _____

City/State/Zip: _____

I give you permission to contact the above individual for the purpose of verifying that I or a family member have a disability and need the reasonable accommodation requested above. I understand the information you obtain will be kept completely confidential and used solely to determine whether or not you will provide an accommodation.

Signature of Head of Household

Date

