The Housing Authority of the County of Cook
REQUEST FOR REASONABLE ACCOMMODATION

Note: This form is to be completed by the Applicant, Resident, or Participant for self or on behalf of a family member, and may be submitted to the Housing Authority of the County of Cook (HACC) at any time. **If you need assistance completing this form,** or you have any additional questions or concerns, please contact HACC at (312) 542-4683

_____ _____

Date of Request *Client Number*

_____ _____

Name of Applicant/Resident/Participant *Phone No.*

1. Reasonable accommodation requested:

_____

(What you need HACC to do to accommodate you, in your own words AND WHY.)

_____

2. Reasonable accommodation requested for: _____

Household Member's Name

3. Reason for requesting this accommodation: _____

_____

(Please state why you need it. And when you need it)

4. You will need to provide proof of your need for the accommodation. Information may be provided from your doctor or other medical professional, a peer support group, a non-medical service agency, or a reliable third party who is in a position to know about the person's disability. The independent party may complete the attached Reasonable Accommodation Third Party Verification form. [The attached form is NOT to be completed by you.]
5. The doctor who provides the information for the accommodation must sign the form, print their name, and include their Illinois Medical license number. The form should also have a letter attached to it that CLEARLY answers the medical questions that are included on the form and gives the doctor's medical opinion whether or not they believe that the requested accommodation is appropriate for you. Forms or letters that are incomplete will not be considered enough information and more information will be required; this will delay the time it takes to grant or deny the request.
6. If your request involves a transfer, you will need to also complete a Transfer Request Form. If your request involves the addition of a Live in Aide, you will need to complete additional Live in Aide forms.

7. **I hereby understand, acknowledge, and certify as follows**: (a) That I had a full opportunity to read and consider the contents of this authorization, and by signing this form, I am confirming that the information in this Request for Reasonable Accommodation is true and accurate. (b) I give HACC permission to talk with my physician or other professional, reliable third party or Case Manager who has completed the verification for the reasonable accommodation requested. (c) This authorization will expire 6 months from

the date it is signed. (d) I have the right to revoke this authorization at any time by giving written notice of my revocation to HACC.

By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are, to the best of my knowledge, true and accurate.

_____ _____

Date *Signature of Applicant/Resident/Participant*

Please return the completed and signed form and the Certification and Third Party Verification to:

Housing Authority of the County of Cook
ADA/Section 504 Coordinator
175 W. Jackson Blvd., Suite 350
Chicago, IL 60604

FOR HACC USE ONLY:

Request was: ☐ Approved ☐ Denied

Alternate reasonable accommodation was offered, as follows:
Date of contact: _____ **Who contacted:** _____

Alternative accommodation offered was _____
(Describe the alternate accommodation offered)

Alternative accommodation was ☐ **Accepted** ☐ **Refused**

Appeal of Decision filed: ☐ **Yes** ☐ **No**
Result of Appeal: _____

HACC
HOUSING AUTHORITY OF THE COUNTY OF COOK

CERTIFICATION OF NEED FOR REASONABLE ACCOMMODATION AND THIRD PARTY VERIFICATION

This form is preceded by the Request for Reasonable Accommodation to be completed by the Applicant, Resident or Participant. All fields must be filled out, and the form must be signed and completed in full by an independent person, not by the Applicant, Resident, or Participant.

Date: _____
Name of party requesting the Reasonable Accommodation_____ _____ Client Number (if known) _____
Address_____
City_____ State_____ Zip: _____

Please return to the ADA/Section 504 Coordinator, Housing Authority of the County of Cook, 175 W. Jackson Blvd., Suite 350, Chicago, IL 60604. Telephone: (312) 542-4683 TTY: (312) 341-1450 Fax: (312) 692-0115

Important: this form is to be completed by a doctor who is familiar with the person's disability and need for the requested accommodation. This section may <u>not</u> be completed by the Applicant, Resident, or Participant.

We are not inquiring as to diagnosis, treatment, or the extent and severity of the disability.
Explanation: The Housing Authority of the County of Cook (HACC) is required by law to provide reasonable accommodations to disabled applicants, residents, and participants in its programs when the accommodations will facilitate their ability to function and provide equal opportunity to use and enjoy our housing programs. Applicable federal and state law defines "disability" with respect to the individual as (1) a physical or mental impairment which substantially limits one or more of such person's major life activities; (2) a record of having such an impairment; but such terms do not include current illegal drug use or addiction to a controlled substance, or an alcoholic who poses a direct threat to property or safety because of alcohol use. The following questions may help determine whether the applicant, resident or participant (or a member of the household) has a disability:

1. I have knowledge that _____
(Name of Applicant/Resident/Participant or Household Member)

2. **Has a physical or mental impairment** ☐ Yes ☐ No

If yes, what is the impairment? ☐ Physical ☐ Mental

3. Is the impairment long-term or permanent? ☐ Yes ☐ No

If not permanent, how long will the impairment likely last? _____
(Indicate months or years)

4. Please answer the following questions based on <u>what</u> <u>limitations</u> the applicant, resident or participant has when his or her condition (or the family member's condition) is in an active state and what limitations the applicant, resident or participant would have if NO mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, haring aids, mobility devices, the use of assistive technology, reasonable accommodations, or auxiliary aids or services, prosthetics and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

5. Does the impairment substantially limit a major life activity? ☐ Yes ☐ No

If yes, what major life activity (ies) is/are affected?

☐ Caring for Self	☐ Walking	☐ Hearing	☐ Lifting	☐ Other:
☐ Interacting with others	☐ Standing	☐ Seeing	☐ Sleeping	(describe)
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating	
☐ Breathing	☐ Thinking	☐ Learning	☐ Reproduction	
☐ Working	☐ Toileting	☐ Sitting		

6. Does the impairment substantially limit the operation of a major bodily function?

☐ Yes ☐ No

Note: Does not need to significantly or severely restrict to meet this standard.

If yes, what major bodily function(s) is/are affected?

☐ Immune	☐ Hemic	☐ Circulatory	☐ Other: (describe)
☐ Normal Cell Growth	☐ Special Sense Organs /Skin	☐ Endocrine	
☐ Digestive	☐ Lymphatic	☐ Reproductive	
☐ Bowel	☐ Neurological	☐ Musculoskeletal	
☐ Bladder	☐ Brain	☐ Special Sense	
☐ Genitourinary	☐ Respiratory	☐ Cardiovascular	

Questions to help determine whether an accommodation is needed:

An applicant, resident or participant (or member of the household) is entitled to an accommodation only when the accommodation is needed because of the disability. Federal regulations stipulate that requests for accommodations will be considered reasonable if they do not create an undue financial and administrative burden for the Housing Authority, or result in a fundamental alteration in the nature of the program or services offered. The following questions may help determine whether the requested accommodation is needed because of the disability.

(You may use additional sheet, if necessary. You do not have to state the nature and severity of the disability).

7. What limitation(s) is interfering with the participant's enjoyment of our programs and services?

_____

_____

8. How does the limitation(s) interfere with his/her ability to have full enjoyment of our programs and services?

_____

_____

9. Please add the extent to which this limitation interferes with his/her ability to full enjoyment of our programs? (For example if the limitation is walking, YOU MUST state what is the distance the applicant, resident or participant (or household member) can walk. You may give distances and/or how long the applicant, resident or participant can stand. If the limitation is lifting, please state the maximum pounds the applicant, resident or participant can lift and

the maximum time limits. If the request is for the addition of a live-in aide or caretaker, please provide the particulars of services needed and the length of time (hours or days) that assistance is needed.)

_____

_____

10. Are there any other alternate accommodations or modifications that could meet the applicant's, resident's, participant's or household member's needs in place of what the applicant, resident, participant or household member has requested. For example, if there is an alternative way to enable the applicant, resident, participant or household member to have full enjoyment of the apartment and/or the apartment community, please give details here:

_____

_____

11. How long have you been treating the household member? Please do **not** include specific details of treatment).

_____

12. Please state your qualifications or professional credentials to make this verification, please also list your Illinois Medical License Number if you are a physician or licensed by the state:

_____

CERTIFICATION:

I understand that I may be contacted by HACC's staff to verify the information I have provided or to provide further information/clarification regarding this request. Furthermore, I understand that I may be contacted or otherwise subpoenaed to provide testimony in a court of law, administrative hearing and/or other legal action with respect to the information I have provided herein or related to this document.

If not able to provide testimony, you must state the reason: _____

By signing this document, I certify under penalty of perjury that the information and statements I have provided as part of and/or in support of this request for a reasonable accommodation are to the best of my knowledge true and accurate.

_____	_____
Signature	Date
_____	_____
Printed Name	Phone:
_____	_____
Professional Title	Fax: