STATE OF GEORGIA
Georgia Department of Community Affairs (DCA)

REQUEST FOR REASONABLE ACCOMMODATION

DCA personnel want to make our services and facilities accessible to all. Your requests and recommendations are welcome. If you know in advance that you will require accommodation services, please complete this *Request for Reasonable Accommodation Form* and return to a Division Coordinator (see attached list with email and telephone numbers) or e mail it to fairhousing@dca.ga.gov.

If you need assistance completing this form, contact the Division Coordinator.

Note: Some types of reasonable accommodations (e.g., readers, sign language interpreters, brailled/alternative formatted materials) require advance notice. ***Requests for reasonable accommodations will be evaluated on a case by case basis. There must exist a nexus or connection between your condition and the accommodation(s) that you are requesting.***

You may be required to complete a *Documentation in Support of Request Form* and *Limited Medical Release* for DCA to properly evaluate your reasonable accommodation request(s). *This information, if required, will remain* ***confidential*** *and will only be used to evaluate your accommodation request(s).*

Name: _____

Address: _____

_____

_____

Telephone No.: _____

E-mail: _____

I am participating in the following DCA service/program/activity as a (check all that apply):

☐ Program Name _____

☐ Other (please specify):

_____

I am requesting accommodation because (please check one or more of the following)

☐ I am requesting accommodation that will allow me to participate in a program or activity offered by DCA.

☐ I am requesting an exception to the following rule, policy or procedure. Please specify the reasons necessary for the exception and the exception requested.

_____

_____

☐ Auxiliary Aid or Service (for example, sign language interpreter, the way that DCA communicates with you).

Please specify:

_____

Describe the impairment that necessitates the accommodation(s) (specify):

_____

_____

Describe the accommodation(s) you are requesting and explain how the requested accommodation(s) would be effective.

_____
_____
_____
_____

Are you aware of alternative methods that might effectively accommodate your impairment?

Yes ☐ No ☐ If yes, specify:

_____

_____

List all dates/times the accommodation(s) are needed (specify):

_____

_____

Please identify any potential resources or other suggestions for DCA to consider in responding to your accommodation requests.

_____

I request that all information pertaining to my accommodation request:

☐ Be kept confidential ☐ *Not* be kept confidential

Date: _____

_____ _____

(Print Name) (Signature)

Review and Action

Reasonable Accommodation Request Form received from applicant on _____ (Date).

If necessary, Request for Additional Information requested on _____ (Date).

If necessary, Request for Additional Information completed and returned on _____ (Date).

☐ Requested Accommodation ***granted*** on _____ (Date).

☐ Requested Accommodation ***denied*** on _____ (Date) because:

_____

_____

☐ Other action taken (explain) on _____ (Date).

_____

_____

Notification to applicant concerning action taken on _____ (Date).

_____ _____

(Date) (Signature of DCA Official)

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REASONABLE ACCOMMODATION REQUEST

Documentation in Support of Request: Health Care Professional Information

Please answer the following questions regarding _____'s condition
Individual
as it relates to his/her ability to participate in _____ and
Program
possible accommodations. _____ signed *Limited Medical*
Individual
Release is also attached.

This information is requested so that DCA can properly evaluate this individual's request for an accommodation to participate in _____
Program

Does the individual have a mental or physical impairment that substantially limits a major life activity? If so, describe the impairment and its impact on this individual's major life activities. (Major life activities include, but are not limited to, walking, seeing, hearing, speaking, breathing, learning, performing manual tasks, caring for oneself.)

Does the impairment affect the individual's ability to participate in the essential eligibility requirements for the program? If so, please describe the impact on the person's ability to perform specific functions.

Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

_____

_____

_____

_____

Health Care Professional name (please print)	Professional license or specialty
Signature	Date

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REASONABLE ACCOMMODATION REQUEST

Documentation in Support of Request: Release

I hereby authorize _____ to provide the medical information requested by DCA. The information will solely be used to evaluate my request for reasonable accommodation under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

_____ _____
Name (Please print) Telephone/E-mail

_____ _____
Signature Date

[Attach cover letter from DCA explaining reason for requesting information.]