Brian P. Kemp
Governor

Christopher Nunn
Commissioner

GEORGIA DEPARTMENT *of* COMMUNITY AFFAIRS

Reasonable Accommodation Request

The Georgia Department of Community Affairs is committed to providing equal access to housing programs and services for individuals with disabilities in accordance with federal laws. A reasonable accommodation is a change or adjustment that may be necessary for a person with a disability to have equal access to and enjoyment of housing programs and services. This form is intended to assist individuals in requesting a reasonable accommodation and to ensure requests are reviewed promptly and confidentially.

This section must be completed by the Housing Choice Voucher (HCV) applicant/participant or by an authorized representative acting on the applicant's/participant's behalf.

Applicant / Participant Information:

Head of Household: _____ **Request Type:** ☐Applicant ☐Participant

T Code: _____ **Member Needing Accommodation:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone Number: _____ **Email Address:** _____

Type of Request:

Please check all that apply:

☐ Communication Assistance (interpreter, large print, etc.) ☐ Voucher Extension ☐ Portability

☐ Unit Change ☐ Live-In Aide ☐ Increase in Payment Standard ☐ Extra Bedroom

☐ Medical Equipment Accommodation ☐ Other: _____

Requested Accommodation:

Please describe the accommodation you are requesting:

_____

_____

_____

Reason for Request:

Please explain how this accommodation is necessary for you or a household member to fully access and participate in housing programs or services:

_____

_____

_____

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or representative of the U.S. Government, punishable by a fine not to exceed $250,000 and/or imprisonment of not more than 5 years.

Verifier's Contact Information:

DCA may require verification from a qualified third-party professional when the disability or disability-related need for the accommodation is not readily apparent or known.

Organization: _____ Provider/Professional's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax/Email: _____

Applicant/Participant Certification

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that submission of this request does not guarantee approval, and that additional information may be requested if necessary.

Name: _____ Signature: _____ Date: _____

THIS SECTION MUST BE COMPLETED BY A PROFESSIONAL KNOWLEDGEABLE OF THE NEED FOR THE REQUESTED ACCOMMODATION

Verification:

I certify that I am a qualified medical or healthcare professional familiar with the patient's condition and functional limitations. Based on my professional knowledge and assessment, the requested accommodation is necessary to provide the individual with equal access to and enjoyment of housing programs and services. The information provided is true and accurate to the best of my knowledge.

The functional limitation(s) caused by the disability is/are (do not provide diagnosis): _____

_____

Describe the type of accommodation or modification needed: _____

_____

How does this accommodation alleviate the functional limitation, and ensure equal housing opportunity? _____

_____

_____

Length of time accommodation is needed: ☐ Up to 1 Year ☐ Up to 2 Years ☐ Permanently ☐ Other: _____

Square footage needed for medical equipment, if requested: _____ ☐ N/A

Member in need of reasonable accommodation is a patient/client of our practice/agency? ☐ Yes ☐ No

Name: _____ Signature: _____

License #: _____ Date: _____

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