

Housing Authority of the City of Alameda
701 Atlantic Avenue, Alameda, CA 94501-2161
TEL: (510) 747-4300
FAX: (510) 522-7848

Date sent: _____
Date rec'd: _____
Logged: _____
Yardi T# _____
Annual: _____ / _____
New RA <input type="checkbox"/> Cont. RA <input type="checkbox"/>

REQUEST FOR A REASONABLE ACCOMMODATION

Instructions: This form may be used by clients to request a reasonable accommodation so that they may have an equal opportunity to use and enjoy participation in any of the programs conducted by the Housing Authority of the City of Alameda. The continued need for a reasonable accommodation may be re-verified at the time of the annual re-examination. **Please complete this form and return to the Housing Authority of the City of Alameda within two weeks of date sent.**

Name of Head of Household: _____

(Please Print)

Social Security Number

Address

Phone Number

1. The following household member (name) _____, has a Disability, defined as: **A physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment, or being regarded as having such an impairment.**

2. Describe the accommodation you are requesting: (examples: live in Aide, extra bedroom, ground floor unit or waive Alameda residency requirement under Section 8 HCVP.)

3. Describe why this accommodation is needed and how it relates to the disability of the above named household member.

4. List the name of the qualified professional who has direct knowledge and experience with the Household member's disability, who can verify the disability, and the need for the accommodation requested.

Name and Position, e.g., physician, nurse)

Telephone Number

Address: _____

Authorization to Release Information: I authorize the health care provider listed above to disclose relevant information to the Housing Authority of the City of Alameda regarding the need for a reasonable accommodation for the above named household member. I understand that the information the said Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.

Signature of Head of Household / Date

Signature of disabled family member
18 year of age or older / Date

