Notice of Right to Reasonable Accommodation

(Confidential Information. This information will not be disclosed or released, except as permitted by law.)

The requirement to provide reasonable accommodation is intended to provide, for persons with disabilities, **equal opportunity** to participate in housing programs through modification of policies, procedures, or structures. This policy **is not intended to provide greater program benefits** to persons with disabilities than to non-disabled program participants or applicants.

If you have a disability and you need:

1. a change in the rules, policies, or procedures that would make it easier for you to **a)**receive rental assistance, **b)** live or use our facilities, ***or*** **c)** take part in programs on site;

2. ***for units owned by the Housing Authority*** a repair or change in your apartment or a special type of apartment that would make it easier for you to live and use the facilities or participate in our programs on site;

3. a repair or change to some other part of the ***housing site, owned by the Housing Authority,*** that would make it easier for you to live and use the facilities or take part in programs on site; or

4. a change in the way we communicate with you or give you information including but not limited to, appropriate auxiliary aids, Telecommunications Devices for the Deaf-TDD, qualified sign language interpreters, or other alternate communication formats.

You can ask for this change, which is called a "REASONABLE ACCOMMODATION."

If you can show that you have a disability and if your request is reasonable, and does not create an undue financial burden, does not create an undue administrative burden or fundamentally alter the nature of the program, we will consider the changes you request.

We will provide you with a written decision as soon as possible, but not later than fourteen (14) days after your request, unless we determine that additional time is necessary to verify your request. We will let you know if we need more information or verification from you or if we would like to discuss other ways of meeting your needs.

If we turn down your request, we will provide you with a written explanation of the reasons. You can give us additional information if you think that will help.

We will verify that the need for your accommodation is based on a qualifying disability. We will request verification from a qualified professional. **"Qualified professional" includes**, but is not limited to, medical providers, psychiatric care providers, licensed social workers, or other care providers who are licensed and practicing and are familiar with your disability related needs. The qualified professional must be a person who does not reside with the family, and is not related to the family by blood, marriage, adoption or other manner. The PHA reserves the right to determine whether or not the person making the certification meets the definition of "qualified professional".

If you need help in filling out a **Reasonable Accommodation Request Form, or it you want to give us your request in some other form, we will help you.

Department of Housing Services
111 NE Lincoln Street, Suite 200-L, MS 63, Hillsboro, OR 97124-3072
(503) 846-4794 • fax (503) 846-4795 • TTY (503) 846-4793
www.co.washington.or.us/housing
Equal Housing Opportunity

There is a **Reasonable Accommodation Request Form** attached to this notice. You may request a **Reasonable Accommodation Request Form** any time you wish to request a reasonable accommodation.

For lease violation, eviction or termination from the program:
If this problem is a result of a disability, you have a right to a reasonable accommodation (See "Request for Consideration of Mitigating Circumstances") -- creating a plan that would enable you to meet the terms of the lease. If you think such a plan or change is likely to correct the problem, you can ask to speak to the program manager or the Department's 504 Officer. If you make such a request, you will need to provide some evidence that the problem was caused by the disability and that the plan is likely to work. If the plan involves someone else, you need to provide verification that they will provide the required assistance.

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WASHINGTON COUNTY
OREGON

Request for Reasonable Accommodation

(Confidential Information. This information will not be disclosed or released, except as permitted by law.)

Printed Name:	Telephone:
Address:	

1. The following member of my household has a disability:_____

2. Please provide the following change or changes so that the person listed above can have **equal opportunity** to participate in the housing choice voucher program and live here as easily or successfully as the other residents. ***From the options below, Check (☑) the kind of change(s) you need.***

☐ **I need a change in my apartment or other part of the housing complex.** Please tell us what you need. Use another sheet of paper, if necessary.

OR

☐ **A change in the following rule or the way the Department does things. What rule or policy is preventing you from using your rental assistance or finding housing? What are you asking us to change? Describe the accommodation you are requesting** (I understand that I may ask for changes in how I meet the terms of the lease, but that everyone must continue to meet the terms of the lease.) Please tell us what you need. Use another sheet of paper, if necessary.

3. **I need this reasonable accommodation because**: Describe how this accommodation will assist you in having equal opportunity to participate in the housing program. (Please attach additional sheets as necessary).

4. What qualified professional may we contact to verify that you have a disability and that your requested accommodation is directly related to your disability? *[The following may provide verification of a resident's disability and the need for the requested accommodation(s): (a) Physician; (b) Licensed healthcare professional; (c) Professional representing a social service agency; or (d) Disability agency or clinic] see definition on page 1.*

Professional's Name: _____ Title: _____

Address: _____ Phone: _____

5. **If you asked for a change to your apartment** or **to the housing complex**, please use this space to list any company or organization that might help us locate or build anything special that you need. (If you don't know of any, we will try to get this information ourselves.)

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Revised 3/2012

AUTHORIZATION TO DISCLOSE MEDICAL AND PERSONAL INFORMATION

By signing below, I hereby authorize Washington County Department of Housing Services and its staff to contact the individual or agency listed above to obtain any information or materials which are deemed necessary to make a determination regarding my request for Reasonable Accommodation. I hereby authorize the individual or agency listed above to release and to disclose to the Washington County Department of Housing Services any records and/or information relating to the disability for which I am requesting reasonable accommodations. The information will be used for the purpose of evaluating my request for reasonable accommodation under the Americans with Disabilities Act (ADA). I understand that I have no obligation to disclose any information from my medical or personal records, and all information disclosed pursuant to this release shall be treated as confidential. I also understand that I may revoke this consent at any time by notifying the individual or agency listed above in writing of my decision, unless they have disclosed the information in reliance on this statement of consent.

I HAVE READ THIS FORM OR HAVE HAD IT READ AND EXPLAINED TO ME AND I FULLY UNDERSTAND ITS CONTENTS.

Signed:	Date:

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