Housing Authority of Thurston County
1206 12th Avenue SE ° Olympia, WA 98501
360-753-8292 ° Fax: 360-586-008
www.hatc.org

NOTICE TO APPLICANTS/PARTICIPANTS WITH DISABILITIES REGARDING REASONABLE ACCOMMODATION

The Housing Authority of Thurston County (HATC) is committed to providing accommodations to persons with disabilities to help ensure that their living arrangements are comparable to those of other Section 8 participants. Accommodations must be reasonable, meaning they cannot cause either undue financial or administrative burden or a fundamental alteration in the nature of HATC's programs.

Reasonable accommodation requests may be made in any convenient manner, including written or verbal, to any Section 8 staff member. Although not required, requests made in writing will simplify processing and will help avoid misunderstandings. HATC's request for accommodation forms are designed to assist Section 8 participants. If you do not or cannot use the attached forms, HATC will still respond to your request for an accommodation.

Requests for reasonable accommodations will be considered on a case-by-case basis because people with the same disability may not need or desire the same type of accommodation.

If you make a reasonable accommodation request, HATC may request reliable documentation (not medical records) that you have a disability and verification of the need for the particular accommodation(s). HATC will not ask questions about the nature or severity of the disability except as specifically related to the requested accommodation. The type of verification you will need to provide depends on the specifics of the situation. The verification may be provided by any third party provider familiar with your disability on forms that the Housing Authority provides or in a separate note/letter. A signed release of information with your provider may help clarify your needs, but such a release is not required.

You may request assistance with completing the attached forms or ask that the forms be provided in an equally effective format or means of communication, such as:

- Qualified interpreters
- Use of Telecommunicatons Relay Services
- Large print materials
- Qualified readers
- TTY

While most decisions are made in less time, we will make every effort to render a decision within forty-five (45) calendar days.

If you have any questions or require additional information on the reasonable accommodation process or procedures, you may contact your housing program specialist or our main office at 360-753-8292.

Please return this form in person or by mail to: Housing Authority of Thurston County, 1206 12th Ave SE, Olympia, WA. 98501. Or you may fax the completed forms to (360) 586-0038.

OFFICE USE ONLY
Household ID:

REQUEST FOR A REASONABLE ACCOMMODATION

Please check one: ☐ Section 8 Applicant ☐ Section 8 Participant

Head of Household:_____ Phone/Cell: _____

Address: _____

Email Address _____

1. The following member of my household has a disability as defined as follows: (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.)

   Name: _____

   Date of Birth: _____

2. I need this reasonable accommodation so that I can:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

3. You may verify that I have a disability and my need for this request by contacting: (This is the name of the third party professional familiar with your disability).

   Name:_____
   Address:_____
   Phone: _____
   Fax: _____

I permit you to contact the above individual for purposes of verifying that a family member or I have a disability and needs the reasonable accommodation requested above. I understand that the information you obtain will be kept entirely confidential and used solely to determine if you will provide an accommodation. This form should be signed by either the member of the household with a disability or the Head of Household if disabled household member is a minor.

Signed:_____ Date: _____

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Dear Professional:

_____is an applicant for either admission to or continued occupancy in our Housing Authority of Thurston County Section 8 Federal Housing Assistance program. They have indicated that they or a family member have a disability that requires an accommodation.

Federal laws require public housing providers to make changes to rules, policies, and procedures, as a reasonable accommodation, if such changes are necessary to enable a person with a disability to have equal access to, and enjoyment of, their housing. **Please note that such changes must be medically necessary as a result of the person's disability as opposed to a change that merely benefits the individual**.

Please specify on the enclosed Verification of Need form the accommodation that you recommend for the person named above. Also, indicate whether you believe the individual has a disability with the definition provided and whether the accommodation is necessary and would achieve its stated purpose. You may also add or provide additional information that would help make the appropriate accommodation decision for this person.

This form should not be used to discuss the person's specific disability or diagnosis or any other information that is not directly relevant to the request for an accommodation; however, it is essential to be as specific as possible about this individual's housing needs as they relate to their disability so that we may provide the most appropriate response.

The individual requesting the accommodation has signed a Release of Information form (enclosed) allowing you to provide the information necessary to assist us in making our determination. If you have any questions feel free to contact me at 360-918-58_____.

Sincerely,

Housing Program Specialist II

VERIFICATION OF NEED FORM: This form must be completed by a qualified professional whose function is to provide services to the below-named person with a disability. It is important to be as clear as possible about what is being requested to help us provide the most appropriate response.

The Housing Authority of Thurston County (HATC) Section 8 participant named below has applied for a reasonable accommodation and is requesting that you, _____, as his/her provider, fill out the following certification. Page 2 is a copy of the Request for Reasonable Accommodation Form completed by the Section 8 participant with his/her signature for release of information.

Individual Member of Household with disability requesting accommodation (from page2):
_____

1. Please describe any reasonable accommodation needs that are medically necessary as a result of his/her disability in order for him/her to enjoy an equal housing opportunity (for example 24-hour live-in-aide with overnight support for activities of daily living (ADLs), additional bedrooms, higher rent standard, rent from family, voucher extension, mutual lease termination, voucher port, etc..): Feel free to provide additional documentation.

_____
_____
_____
_____

Definition of Live-in Aides (24 CFR Section 5.403): a person who resides with one or more elderly persons, near-elderly persons, or persons with disabilities and who is 1) determined to be essential to the care and well-being of the persons, 2) is not obligated for the support of the persons, and 3) would not be living in the unit except to provide the necessary supportive services. The family must identify the live-in aide, and the Housing Authority must approve them. Occasional, intermittent, multiple, or rotating caregivers do not meet the definition of a live-in aide since 24 CFR Section 982.402(7) implies live-in aides must reside with the family permanently for the family unit size to be adjusted per the subsidy standards established by the PHA. Therefore, regardless of whether these caregivers spend the night, an additional bedroom should not be approved.

In my opinion, the named person has a disability as defined below:

1. A physical or mental impairment which substantially limits one or more of this person's major life activities; ☐ **YES** ☐ **NO**

2. A record of having such an impairment; or ☐ **YES** ☐ **NO**

3. Is regarded as having such an impairment (does not include current, illegal use of or addiction to a controlled substance as defined in section 102 of the Controlled Substance Act, 21 U.S.C. 802). ☐ **YES** ☐ **NO**

Print Name	Signature	Date
Title of Physician/Professional	Street Address	Telephone/Fax

Agency/Practice City State Zip

FOR HATC USE ONLY

Does the applicant/participant qualify as an individual with a disability? ☐ **YES** ☐ **NO**
Please explain and attach verification used:

_____

Signature of HPS or other designee Date