1540 Webster Street, Oakland, CA 94612

Request for Reasonable Accommodation

Date of Request: ____________

Name of Resident or Applicant: ________________________________ **Client #**:____________

Address: ______________________ **City:** __________________ **State**: _____ **Zip**:_______

Phone Number: ______________________ **Message Number:** ___________________

1. The following household member,_________________________________, has a disability as defined below:

   A physical or mental impairment that limits one or more of the person's major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working); and has a record of having, or being perceived as having, a physical or mental impairment. It does not include current illegal use of, or addiction to, a controlled substance

2. Reasonable accommodation requested: ***Example: Live-in aide, additional bedroom/increase in subsidy.***

   ____
   ____
   ____

3. Reason for requesting this accommodation: ***(Why is this accommodation needed?)***

   ____
   ____
   ____
   ____
   ____

4. List the name of your doctor, health care provider or other qualified individual who can verify the request:

   Name:____ Title___________________________

   Address:____

   Phone:_______________________________ Fax Number:_______________________________

The verification form is printed on the back of this request for your convenience.
If you have any questions about completing this form, please contact:

____ ______________________________
Oakland Housing Authority Representative Phone Number

Reasonable Accommodation Verification

Important: *This independent verification is to be completed by a doctor, licensed professional representing a rehabilitation center, or the supervisor or case manager representing a disability agency.*

Name of Patient:________________________________ Medical Record Number:___________________

Address:______________________________________ Telephone Number: (____) _________________

City/State/Zip:_________________________________

I authorize the release of information, relative to my physical or mental impairment, in order to verify the reasonable accommodation I have requested on the backside of this form.

Signature:_____________________________________ Date: ____________________

The Oakland Housing Authority is required by law to provide reasonable accommodations to disabled applicants, residents, and participants that will facilitate their ability to function and provide equal opportunity to use and enjoy our housing programs. Applicable Federal and state law defines "disability" with respect to the individual as (1) a physical or mental impairment that limits one or more of the person's major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working); (2) having a record of having, or being perceived as having, a physical or mental impairment. It does not include current illegal use of, or addiction to, a controlled substance. _______________________ has been my patient since ____/_____/_____.
(Patient's Name)

Due to his or her disability, the patient has the following functional limitations:

____

____

and requests that the Oakland Housing Authority provide the following reasonable accommodation(s) to give equal access to housing. An explanation of why the accommodation(s) is needed below: ***(Use additional sheets if necessary.)***

A. Physician or licensed professional, please explain the relationship between the accommodation and the disability (why the accommodation is necessary to assure equal access to housing).

____

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____

____

____

B. The patient requires [ ] long-term [ ] short-term accommodation.
Please specify the duration required: ________________ months/years

C. [ ] In my professional assessment, the patient's disability **does not** justify the accommodation requested.

The statements and opinions I have given are true and correct to the best of my knowledge.

_______________________________________ _____________________________

Physician's Signature Date

_______________________________________ _____________________________

Print Name and Title Medical License Number

_______________________________________ _____________________________

Address Phone Number

Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdictions, punishable by fine not to exceed $250,000 and or imprisonment of not more than 5 years.