HOUSING AUTHORITY OF THE COUNTY OF SAN BERNARDINO

REASONABLE ACCOMMODATION REQUEST

Date of Original Request: _____ ☐Verbal ☐ Written (check one)

Date Form Completed (If Different from Date of Original Request): _____

Family Head of Household: _____

Address: _____

Cell Phone: _____ Home Telephone: _____

Email Address: _____

☐ Medical Documentation Attached. *You do not have to attach medical documentation to this request to invoke your rights to reasonable accommodation. Verifications may be obtained after you submit your request, but before a decision is made.*

I am requesting the following reasonable accommodation(s):

_____ Live-in Aide

_____ Additional Bedroom

_____ Assistance required completing paperwork

_____ In-home appointment (due to medical condition/age)

_____ Translation service Language needed: _____

_____ Other: (Be as specific as possible) _____

_____

_____

_____

_____

(Please feel free to attach further justification)

_____ _____ _____

Requestor's Signature Phone Number Date

List the name of the health care provider who can verify the disability and the need for the accommodation requested. This should be the individual providing professional services that relate to the disability.

Name: _____ Title: _____

Address: _____

Phone: _____ Fax: _____

Please return completed, signed and dated forms to your local HACSB office or directly to the Property Manager / Caseworker of the Resident / Participant.