Wichita Housing Authority
Request for A Reasonable Accommodation

Dear Participant/Applicant: Please complete the following section of the form.

Please mark the appropriate box:

☐ HCV Applicant ☐ HCV Participant ☐ Public Housing Resident

HOH Name:		Email:	
Address:		Phone:	

Reasonable Accommodation request completed on behalf of: (Check one of the following):

☐ Head of Household ☐ Family Member (Please Name): _____

The individual, named above, who needs the reasonable accommodation, meets the definition of an individual with a disability as stated on page three.

☐ Yes ☐ No

The change in policy or physical unit modification requested for the disabled individual:

_____

_____

_____

_____

_____

I authorize the physician/health care provider named below to release the specific information requested on the next section of this form to the Wichita Housing Authority to verify my request for reasonable accommodation.

Health Care Provider's Name:		Phone Number:	
Address:		Fax Number:	
		Email:	

Participant Signature: _____ Date: _____

PENALTIES FOR MISUSING THIS CONSENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or representative of the U.S. Government, punishable by a fine not to exceed $250,000 and/or imprisonment of not more than 5 years. False or misleading information can also result in the termination of housing assistance.

The following section is to be filled out by the health care provider:

Section 504 of the Rehabilitation Act of 1973 allows the Public Housing and Housing Choice Voucher Programs to obtain confirmation that the reasonable accommodation request is consistent with the patient/client's disability. Disability is defined on page three of this form.

Please provide the following information concerning your patient's request for a reasonable accommodation. Please note this is not a request for medical records or detailed information about the disability. Please limit your remarks to describing functional limitations and to confirming that the accommodation requested is relevant to this patient/client's case.

Health Care Provider, please fill out the following:

Name of Physician/Health Care Provider:		Street Address:	
		City, State, Zip Code:	
Name of Affiliated Institution, Office, or Organization:		Phone:	
		Fax:	

As a health care provider with knowledge necessary to make such a determination I, _____ (Physician/HCP Name) certify that _____ (Name of person who needs accommodation) qualifies as an individual with a disability as defined on the third page of this form and that the accommodation(s) the patient identified on this form has requested is/are consistent with their needs associated with their disability.

The functional limitations caused by said disability is/are: (DO NOT PROVIDE DIAGNOSIS)

_____

_____

_____

(Check one) **This disability is:** ☐ Permanent **or** ☐ Temporary

The change in policy or physical unit modification needed is:

_____

_____

_____

How does the change in policy or physical unit modification alleviate the functional limitation so that the member can have equal, not superior, housing opportunity?

_____

_____

_____

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Signature of Physician or Health Care Provider: _____ Date: _____

SECTION 3: DEFINITIONS

Assistive Animals: Animals that serve as a reasonable accommodation for persons with disabilities by assisting those individuals in some identifiable way by making it possible for them to make more effective use of their housing.

Disability: According to the Fair Housing Act amended in 1989 and Section 504 of the Rehabilitation Act of 1973-as amended, a person with a disability includes any person who has:

- Physical or mental impairment(s) that substantially limits one or more major life activities;
- Has a record of having such impairments; or
- Is regarded by others as having such impairments.

Examples include, but are not limited to: visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV, mental retardation, emotional illness, drug addiction and alcoholism. This definition does not include current illegal use of, or addiction to, a controlled substance as defined in Section 2 of the Controlled Substance Act, 21 U.S.C. 802.

Live-in aide: 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 live-in aide must be identified by the family and approved by the Housing Authority. (24 CFR Section 5.403)

Reasonable Accommodation: A reasonable accommodation is a slight change in procedure or policy or structural modification that enables a person with disabilities to take full advantage of the same housing opportunities as others.

If you require an oral interpretation in a language other than English, please call (316) 462-3700.
Si require una interpretacion oral en un idioma que no sea ingles, por favor llame al (316) 462-3700.

WHA OFFICE USE ONLY

Date Request Received:		Housing Specialist:	
HoH Name:		Last 4 Digits of HoH SSN:	

Family Review Form Attached ☐

Staff Narrative: _____

☐ Approved ☐ There is insufficient evidence/documentation to support your request

Compliance Administration Signature: _____ Date: _____

Wichita Housing Authority
455 N Main-10th Floor
Wichita, KS 67202

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Fax: (316) 219-6350
Email:CSC@wichita.gov