PHILADELPHIA HOUSING AUTHORITY
OPENING DOORS TO OPPORTUNITIES

VERIFICATION OF NEED FOR REASONABLE ACCOMMODATION

TO: _____ DATE OF 1st REQUEST: _____
Name

DATE OF 2nd REQUEST: _____

_____ _____ _____ _____ _____
Address City, State Zip Code Telephone Number Fax Number

RE: _____ SSN: _____
Applicant/Client Name

_____ _____ _____
Applicant/Client Address City, State Zip Code

Dear Sir/Madam;

We are required to verify the incomes, expenses and other information of applicants/participants for eligibility and continued occupancy in the Housing Choice Voucher Program. We ask your cooperation by supplying the information requested below about the referenced person. We will use any information you provide to determine the applicant's eligibility for an accommodation under Section 504 of the National Rehabilitation Act and pledge to keep the information in strict confidence.

We would greatly appreciate your prompt return of this letter. A self-addressed return envelope is enclosed. Note that the person referenced has authorized your release of the information. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

_____ _____
PHA Representative Name Telephone Number

APPLICANT/PARTICIPANT RELEASE OF INFORMATION

I,_____ hereby authorize _____ to release the information concerning my (or my minor child _____) needs for accessible housing features and/or accommodations.

Signature: _____ Date:_____

_____ _____ _____
Address City, State Zip Code

TO BE COMPLETED BY A QUALIFIED EVALUATOR OR MEDICAL PROVIDER

1. Is the applicant disabled? ☐ Yes ☐ No
2. Is the disability expected to be of long-continued or of indefinite duration? ☐ Yes ☐ No
3. If the applicant is disabled, does he/she have a physical disability that results in the need for any accessible housing features or accommodations? ☐ Yes ☐ No
   If yes, please describe fully on the next page.

SPECIAL ACCOMMODATIONS NEEDED – CIRCLE ANY THAT MAY APPLY

Yes No Live-In-Aide (fill out Form E, Verification of Need for Caregiver or Live-In-Aide) (5985)

Yes No Separate bedroom required for disabled person (5989)

Yes No Spare bedroom for medical equipment (explain in detail below) (5989)

Yes No Other special needs (explain in detail below) (5900)

SPECIAL UNIT TYPE NEEDED – CIRLCE ONLY <u>ONE</u> TYPE IF APPLIES

Yes No Accessible Unit (zero steps, accommodates wheelchair or other assistive devices) (M1-5100)

Yes No Unit on One Level (can have steps at entry only) (M3-5121)

Yes No Unit with Limited Flights of Stairs (M2 - 5120)

Please provide further information that would assist us to determine the accommodation required by the applicant. We do not require details or information about the nature or extent of the disability:

_____

_____

_____

I certify that the above information is true and correct.

_____ _____
Name of Person Completing Form Title

_____ _____
Signature Date

_____ _____ _____
Name of Organization Telephone Number Fax Number

_____
Address City, State Zip Code

TO BE COMPLETED BY PHA

For PHA Use Only: Data Entry Completed:_____ By: _____

Received and Reviewed by: _____

Is Information Adequate and Complete? ☐ Yes ☐ No Date Received: _____
Notes:

Recommendation: Approved By: _____
(Program Manager)