504 ACCESSIBILITY COORDINATOR
2013 Ridge Avenue
Philadelphia, 19121
Telephone: 215.684.4379
Fax: 215.684.4578
www.pha.phila.gov

Date: _____

Name: _____
Client Number: _____
Address: _____
_____

Dear _____:

We acknowledge your intent to request a Reasonable Accommodation today. Enclosed is a Reasonable Accommodation Request form. Please complete the Release of Information section on page 1. On page 1, please provide contact information for your designated professional and then on pages 2 and 3 check the boxes on the left hand side to indicate what features you believe you need in your unit. **Please return the completed form to the 504 Department within 15 days from the date of this letter.**

To process your request, we need third-party verification of your disability-related need. The Philadelphia Housing Authority will get verification from the professional that you designate on page 1 that your request is related to your disability.

Once we receive the completed Reasonable Accommodation Request form from your designated professional, we will review your request.

If you have any questions, you may contact the 504 Accessibility Coordinator at 215-684-4379.

Sincerely,

504 Accessibility Coordinator
Philadelphia Housing Authority

PHILADELPHIA HOUSING AUTHORITY
OPENING DOORS TO OPPORTUNITIES

Client # _____
1st Attempt _____
2nd Attempt _____

Instructions:

The Philadelphia Housing Authority (PHA) is required to verify the disability of individuals claiming to be disabled to determine eligibility for disabled housing.

1. The applicant/resident must complete all required sections of the form and mail the form to PHA's 504 Accessibility Coordinator.
2. A PHA representative will send the form to the listed medical provider, who must complete and sign this form. PHA must receive verification from your medical provider within 30 days of PHA's request for verification. If your designated medical provider fails to provide verification within 30 days of PHA's request, your request for a reasonable accommodation may be closed.
3. The medical provider must return this form directly to PHA's office by fax or mail (see PHA's contact information above). Copies mailed or hand delivered to PHA by families **will not be accepted**.

Does anyone in your household require a reasonable accommodation? ☐ Yes ☐ No

If you selected "No" to the above question, please print, sign and date below. No further action required:

_____ _____ _____
Printed Name of Head of Household | Signature of Head of Household | Date

If you selected "Yes" to the above question, please continue with completing the form:

For Applicant/Resident to Complete (Release of Information):

Applicant/Resident _____Date of Birth: _____
(Print the name of the person with the disability)

I currently reside at_____
(Print full address :) street apt. no. city state zip code

My phone # _____ Head of Household _____

I authorize _____ to release information to PHA to verify my disability and the need for an accommodation.
(Name of professional/organization)

Applicant/Resident/Guardian (sign name) _____ Date: _____

**If this is for a child with disabilities please print Guardian's name* _____

If you are in need of additional assistance or an alternate means of reviewing and understanding this process, please contact 504 Accessibility Coordinator at 215.684.4379.

Medical Provider information to whom you want a PHA representative to forward this form:

Name of Medical Provider: _____

Organization Name: _____

Address of Medical Provider: _____

_____

Phone # for Medical Provider: _____

Fax # for Medical Provider: _____

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1st Attempt _____
2nd Attempt _____

MEDICAL PROVIDER ONLY:

A person can be considered disabled in three ways for purposes of reasonable accommodations in housing. A person can be considered disabled if the person:

1. Has a physical or mental **impairment** that substantially limits one or more **major life activities; OR**
2. Has a **history** of such a physical or mental impairment; **OR**
3. Is **regarded as** having such an impairment

Please confirm ONE of the following statements: (Please print the following information requested**)**

In my professional opinion, I certify that _____

- ❑ **Has a qualifying disability as defined by category above.**
- ❑ **Does not have a qualifying disability as defined by any of the categories**
- ❑ **I have no knowledge of a qualifying disability as defined by category above.**

***Excluding the disability/diagnosis, please explain how he/she is impacted: _____**

_____

_____

_____

REASONABLE ACCOMODATION:

Applicants/Residents – Select the reasonable accommodations you wish to request on the **LEFT** side of the form.
Medical Professionals – For all accommodations selected by the applicant/resident, initial the **RIGHT** side of the form (Professional Initial Here :) if the accommodation is required.

ASSISTIVE EQUIPMENT UTILIZED: ❒ **None Required**…….…. **Professional Initial Here: _____**

- ❑ Wheelchair (*Select*): ___ Standard ___ Motorized…….. **Professional Initial Here: _____**
- ❑ Scooter …… **Professional Initial Here: _____**
- ❑ Cane/Crutches/Braces…… **Professional Initial Here: _____**
- ❑ Walker…… **Professional Initial Here: _____**

SPECIAL UNIT TYPE NEEDED: ❒ **None Required**…….. **Professional Initial Here: _____**

NOTE: Please only select one type of unit below

- ❑ Unit with zero (M3 – 5121) steps at entry and inside the unit…… **Professional Initial Here: _____**
- ❑ Unit with limited number of steps (M2 – 5120) at entry and in the unit (complete below)
  - Maximum number of steps at entry_____ ……...…….. **Professional Initial Here: _____**
  - Maximum number of steps in unit_____ ……...….. **Professional Initial Here: _____**
- ❑ Fully wheelchair accessible unit (M1 – 5100)…….…. **Professional Initial Here: _____**

SPECIAL FEATURES NEEDED IN UNIT: ❒ **None Required**… **Professional Initial Here: _____**

Bathroom ***(note: fully wheelchair accessible units have accessible bathrooms, please select either tub or roll in shower)***

- ❑ Tub Seat (5220)……..……..…… **Professional Initial Here: _____**
- ❑ Roll-in shower (for wheelchair user) (5250)...…….…. **Professional Initial Here: _____**
- ❑ Tub ……..……..…… **Professional Initial Here: _____**
- ❑ Raised toilet or higher toilet seat (5270)……...…… **Professional Initial Here: _____**
- ❑ Grab bar(s) at toilet (5260)...……..……..…….. **Professional Initial Here: _____**

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Client # _____
1st Attempt _____
2nd Attempt _____

- ❑ Grab bar(s) in bathtub (5210)..…….…… **Professional Initial Here: _____**
- ❑ Hand-held shower (5230) ...……..……..…… **Professional Initial Here: _____**
- ❑ Maneuvering space for a wheelchair in the bathroom (5200) ……...… **Professional Initial Here: _____**

Kitchen *(note: fully wheelchair accessible units have all of these features)*

- ❑ Lowered kitchen sink/counter to 34” ……..……..…… **Professional Initial Here: _____**
- ❑ Base cabinets removed for a wheelchair……..……..……...… **Professional Initial Here: _____**
- ❑ Lowered kitchen wall cabinets to 48” height.……..……...… **Professional Initial Here: _____**
- ❑ Maneuvering space for a wheelchair in the kitchen (5300)…….. **Professional Initial Here: _____**

Other Special Unit Features: ...……..……..……. Professional Initial Here: _____

- ❑ Chair Glide/Stair Lift
- ❑ Features for the deaf/hard of hearing (describe what is needed and where):_____
  _____
- ❑ Features for the vision-impaired (describe what is needed and where):_____
  _____
- ❑ Other (please specify)_____
  _____

❒ LIVE-IN AIDE (5985): ❒ None Required…… Professional Initial Here: _____

This individual requires LIVE-IN assistance related to a disability. This is not verification for aides who come and go such as a caregiver that works specific shifts during the day or night on a regular basis. A live-in aide must meet this HUD definition: A live-in aide is a person who resides with one or more persons with disabilities and who: (1) Is determined to be essential to the care and well-being of the person(s); (2) Is not obligated for the support of the person(s); and (3) Would not be living in the unit except to provide the necessary supportive services. **Please describe the duties of the aide below.**

_____

_____

_____

PROGRAMMATIC ACCOMMODATIONS NEEDED: ❒None Req’d Professional Initial Here: _____

- ❑ Assistance Animal: (*Must specify the role and type of the animal*).. **Professional Initial Here: _____**
  _____
- ❑ Extra bedroom for equipment (*Must specify equipment*) (5989) ……. **Professional Initial Here: _____**
  _____
- ❑ Special location in the City (*Must specify location & reason*) (5986).. **Professional Initial Here: _____**
  _____
- ❑ Special accommodations for visual impairments/Written material in alternate formats (*Must specify format example: Large Print*)……..……..……. **Professional Initial Here: _____**
  _____
- ❑ Special communication needs for the deaf/hard of hearing…….. **Professional Initial Here: _____**
  - ❑ Sign Language Interpreter
  - ❑ Other_____
- ❑ Other (*Specify*): ……..…….. **Professional Initial Here: _____**
  _____

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FOR MEDICAL PROFESSIONAL TO COMPLETE

In my professional opinion, the above individual has a disability and also needs the special features, modifications, and/or change(s) listed above to allow full access to PHA programs and services due to a disability. ***The Fair Housing Act defines a person with a disability as (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; and (3) individuals with a record of such an impairment.***

Name (print):_____

Title: _____

Organization Name and Address: _____

Phone: _____ Fax: _____

Person to contact with questions about form: _____

I declare under penalty of perjury that I have examined all the information on this application for Reasonable Accommodation, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that the Philadelphia Housing Authority is a federally funded agency and that anyone who knowingly gives a false or misleading statement or answer to any question or about a material fact in this application commits a crime and may be sent to prison, subject to subsequent revocation of their license to practice, or may face other penalties. I certify that the information I am providing is accurate and is based on my professional knowledge, training, and experience.

Signature of Professional: _____ **Date**: _____

The certifying professional should return this form to:

504 ACCESSIBILITY COORDINATOR
Fax Number: 215.684.4578

Note: It is important that all 4 pages need to be completed and returned within 15 days from the date the requester received them.

For PHA Use Only
Date Received: _____

_____
Print Name of Reviewer

Information Adequate and Complete? Yes or No
Accommodation Request Attached? Yes or No
Disability Observed? Yes or No

Comments:

Data Entry Completed: _____ By: _____

Site Name: _____

Approved for Accessible Unit? Yes or No

Approved by: _____

Signature: _____